Lutheran Health Network
Lutheran Hospital

Kidney Transplant Candidate Referral Form

Referral Date: _____ Referred By: _____

Patient's Name: _____ SS#: _____ DOB: _____ Race:_____

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Cell: _____ Emergency Contact: _____

Height: _____ Weight: _____ BMI: _____ (Patient's BMI must be ≤ 40 to be considered for evaluation)

Nephrologist: _____ Primary Physician: _____

Dialysis Patient: ☐ Yes ☐ No / Type of Dialysis: ☐ Hemodialysis ☐ CAPD / Dialysis Start Date: _____

Dialysis Center: _____ Phone: _____ Dialysis Days: _____ Shift: _____

Is the patient listed at another transplant facility: ☐ Yes ☐ No If yes, Where: _____

Please include the information below with this referral form:

☐ Patient history and physical	☐ Copy of insurance cards	☐ Medication list
☐ Current lab values	☐ Missed dialysis treatment report (1 year)	☐ Record of recent vaccines
☐ Nephrology dialysis notes	☐ Test or procedure results (CXR, stress test, US, etc.)	☐ **2728 form**

This referral cannot be initiated unless it is completed in its entirety and, when applicable, all requested documents must accompany this form.

PLEASE FAX THIS FORM ALONG WITH ALL REQUESTED INFORMATION TO LUTHERAN TRANSPLANT CENTER @ 260-435-6279

Phone (260) 435-6275 or (800)
7910 W. Jefferson Blvd., Suite 200, Fort Wayne, IN 46804

Thank you,

The Lutheran Kidney Transplant Team