Kidney/Pancreas Transplant Referral Application

Date: _____ ❍ **Kidney** ❍ **Pancreas** ❍ **Kidney and Pancreas** ❍ **Retransplant**

If patient's demographic form is not available, please fill out the following information:

Name: _____

Date of Birth: _____ ❍ Male ❍ Female Marital Status: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Language Preference: ❍ English ❍ Spanish ❍ Other _____

Email: _____

Primary Insurance: _____ Secondary Insurance: _____

Please notify the Primary Care Physician (PCP) of this referral, if required by the insurance company.

REFERRING PHYSICIAN INFORMATION:

Referring Physician: _____ Specialty: _____

Dialysis Center: _____

Address: _____

City: _____ State: _____ ZIP: _____

Dialysis Phone: _____ Office Fax: _____ Office Contact: _____

PATIENT INFORMATION:

Dialysis days and shift: _____ First day of chronic dialysis: _____

Treatment modality: ❍ HD ❍ PD ❍ Pre-Dialysis

Any known allergies: _____ Height: _____ Weight: _____ BMI: _____

IMPORTANT! **Please fax the following information with this form:**

- ❍ Patient's demographic form
- ❍ Copy of insurance cards (front and back)
- ❍ Recent history and health physical
- ❍ Current medication list
- ❍ Immunization records
- ❍ Form 2728, if applicable

The patient will be contacted within 72 business hours by phone or email to confirm that we have received your referral.

NOT PART OF PATIENT MEDICAL RECORD

Referring Hotline: 713.704.5200 or 800.869.5996
Referring Fax: 713.704.0081
Referring Address: Memorial Hermann-Texas Medical Center
6411 Fannin St., Suite J1-400, Houston, TX 77030

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