

Referral Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Referring Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

### Patient Information

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_

SSN: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_

Secondary Phone: \_\_\_\_\_

DOB: \_\_\_\_\_ Race: \_\_\_\_\_ Gender: \_\_\_\_\_

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_

Language of Choice: \_\_\_\_\_ Translator? YES NO

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

At which Emory clinic would the patient like to start the transplant evaluation? Please select preference:

Emory Main    Athens    Acworth    Columbus    Dublin    Savannah    Thomasville

### Required Documentation

Fax Documents to: 404-727-8972

- Primary Insurance Cards: front & back copy
- Secondary Insurance Cards: front and back
- Form 2728
- H&P (within 6 months) - if not available, provide hospital discharge summary, admission H&P or last office visit note
- Recent Labs (within 3 months)
- Medication List
- Completed Referral Form

Patient is not on dialysis

### Medical Information

Dialysis Center: \_\_\_\_\_ CMS Number: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Type of Dialysis:    Hemo    Home Hemo    Peritoneal CAPD    Peritoneal CCPD

Schedule:                    (M/W/F)                    (T/Th/S)

Cause of Renal Failure/ Diagnosis: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Completed by: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Once we receive all referral patient information requested on this form, the patient will typically be seen within 2-6 weeks.

We will notify the patient of appointment date/time, test results, treatment, diagnostic information.

We will provide visit notes to your office using the contact information provided on this form.