EMORY
TRANSPLANT CENTER

_____ Kidney
_____ Kidney/Pancreas
_____ Pancreas

Referral Date: _____

Referring Physician: _____

Practice Name: _____

Referring Address: _____

_____

Phone & Fax Number: _____

Required Documentation
Fax Documents to: 404-727-8972

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

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 or NO

Emergency Contact: _____ Phone: _____

Relation to patient: _____

Insurance Company: _____ Policy Number: _____

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

Emory Main Athens Acworth Dublin Savannah Spivey Station Thomasville Columbus

O Patient is not on dialysis

Medical Information

Dialysis Center: _____ CMS number: _____

Phone: _____ Fax: _____

Please circle type of dialysis: Hemo Home Hemo Peritoneal CAPD Peritoneal CCPD *Schedule:* (M/W/F) (T/TH/S)

Dialysis start date: _____

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 also notify the patient regarding appointment date/time, test results, treatment, diagnostic information. We will provide visit notes to your office using the contact information provided.