EMORY
TRANSPLANT CENTER

Kidney
Kidney/Pancreas
Pancreas

Referral Date: _____
Referring Physician: _____
Practice Name: _____
Referring Address: _____
_____
Phone Number: _____
Fax Number: _____

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 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

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.