

Referral Date: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_  
Practice Name: \_\_\_\_\_  
Referring Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone & 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 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

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.**

**Required Documentation**

Fax Documents to: 404-727-8972

- Primary Insurance Cards: front & back
- Secondary Insurance Cards: front & 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