Clinical Transplant Services
Kidney/Pancreas Transplant Program
Mail Code: CB569 ● 3181 SW Sam Jackson Park Rd. ● Portland, OR 97239 -3098
Tel: 503/494-8500 ● Toll free: 800/452-1369 x 8500 ● Fax: 503/494-4492

KIDNEY/PANCREAS TRANSPLANT REFERRAL FACE SHEET

TO: OHSU KIDNEY/PANCREAS TRANSPLANT PROGRAM
FAX: 503-494-4492

FROM: _____

FAX: _____

Referral is for:

- ☐ Kidney transplant
- ☐ Simultaneous pancreas kidney transplant
- ☐ Pancreas transplant

PLEASE FAX ALL OF THE FOLLOWING:

- ☐ Statement of referral by nephrologist (chart note, intro letter, etc)
- ☐ Completed referral form (including demographics, insurance, and medical history)
- ☐ Patient's most recent H&P (must be from the past 12 months)
- ☐ Last 2 sets of labs (CMP & CBC)
- ☐ Medicare 2728 if on dialysis
- ☐ Rounding report or Treatment Log if on dialysis

And, if available:

- ☐ Recent diagnostics
- ☐ Vaccine history

If we have questions or need additional information, who should we contact?

Name: _____

Phone: _____

KIDNEY/PANCREAS TRANSPLANT REFERRAL FORM

Physician Information

Referring Nephrologist: _____ Date: _____/_____/_____

Address: _____

Phone: (____) _____-_____ Fax: (____) _____-_____

Primary Care Physician: _____

Phone: (____) _____-_____

Patient Information

Name (first, middle, last): _____

Address: _____

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____ Work Phone: (____) _____-_____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Gender: ☐ Male ☐ Female Height: _____ ☐ cm. ☐ inches Weight: _____ ☐kg ☐lbs

English speaker ☐ yes ☐ no, other language: _____(☐ Interpreter required)

Next of Kin: _____ Relationship: _____

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____

Insurance Information

(1)Primary Insurance: _____ ID#: _____

Subscriber: _____ Group #: _____

(2)Secondary Insurance: _____ ID#: _____

Subscriber: _____ Group #: _____

Medicare Part D Plan (if Medicare insured): ☐ No ☐ Yes, _____

ID: _____ Group: _____BIN: _____Phone#: _____

(Kidney Transplant Referral Form, cont. from page 1)

Medical History

Primary Cause of ESRD: _____

ICD-10 Code: _____ Date of Diagnosis: _____/_____/_____

Secondary Cause of ESRD:_____

ICD-10 Code: _____ Date of Diagnosis: _____/_____/_____

Has this patient had a previous transplant? ☐ NO ☐ YES Organ(s):_____

If yes, when? _____/_____/_____ Where: _____

Is this patient on dialysis? ☐ YES ☐ NO If no, what is 24 hour creatinine clearance? _____

If patient is on dialysis what type is it? ☐ Hemo ☐ Peritoneal

Dialysis Unit: _____ Dialysis Schedule: _____

Chronic Dialysis Start Date (according to Medicare 2728)? _____/_____/_____

Please explain any "yes" answers to the questions below:

Prior or current Drug Use?	☐ no	☐ yes… explanation: _____
Compliance Issues?	☐ no	☐ yes… explanation: _____
Active Infection?	☐ no	☐ yes… explanation: _____
Increased Operative Risk?	☐ no	☐ yes… explanation: _____
Current Smoker/Chewer	☐ no	☐ yes… explanation: _____
History of Heart Disease?	☐ no	☐ yes… explanation: _____
History of Malignancy?	☐ no	☐ yes… explanation: _____
History of Stroke?	☐ no	☐ yes… explanation: _____
Anatomy Unsuitable for Tx	☐ no	☐ yes… explanation: _____

Additional comments:

_____
_____
_____
_____
_____
_____
_____
_____
_____

(Kidney Transplant Referral Form, cont. from page 2)

Oregon Health & Science University
Hospitals and Clinics
Health Information Services /
Medical Correspondence
3181 SW Sam Jackson Park Rd,
Mail Code: OP17A
Portland, OR 97239-3098
(503) 494-8521, Fax (503) 494-6970

Patient Identification

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

*ALL SECTIONS OF THIS FORM **MUST** BE COMPLETED OR THE AUTHORIZATION WILL NOT BE ACCEPTED.*

I authorize: _____
(Name of person / entity/ facility disclosing information)

_____ _____ _____ _____
(Address of person / entity) (City) (State) (Zip Code)

to use and disclose an electronic copy of the specific health information described below; unless you check here ☐ for a paper copy. This release is regarding:

_____
(Name of individual)

consisting of: *(see back side for definitions)* ☑ Physician reports ☑ X-rays (*please see the back side of this form for complete instructions*) ☑ Labs ☑ ED ☑ Billing

☐ Other, specify _____

☐ If outpatient practice/clinic records are needed, please specify the practice(s)/clinic(s) *(see back side for practice/clinic list)* _____

to: Oregon Health & Science University Clinical Transplant Services
(Name of recipient)

3181 SW Sam Jackson Park Road Mailcode:CB560 | Portland | OR | 97239
(Address of recipient) (City) (State) (Zip Code)

for the purpose of: *(Describe each purpose of disclosure)* ☑ Continued Care ☐ Legal ☐ Disability
☐ School Entry ☐ Other, specify _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my ***initials*** in the applicable space next to the type of information.

_____ HIV/AIDS information
_____ Mental health information
_____ Genetic testing information
_____ Drug/alcohol diagnosis, treatment, or referral information

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign will mean you will not receive health services is if the health services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any uses or disclosures already made with your permission cannot be undone.

To revoke this authorization, please send a written statement to Medical Correspondence, Health Information Services, OP17A, OHSU 3181 SW Sam Jackson Park Rd. Portland, OR 97239-3098, and state that you are revoking this authorization

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

I have read this authorization and I understand it.

This authorization expires one year from the date of signing unless revoked or otherwise specified below:

(enter alternative expiration date or event) _____

By:_____ Date:_____
(Signature of individual or personal representative)

Description of personal representative's authority:_____

MR1470

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ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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DEFINITION OF REPORTS:

- Physician reports include Discharge Summary, Discharge instructions, History & Physical exam, any procedures or operations
- X-rays include X-ray reports, Ultra sound, MRI, and special Imaging reports (**If you are requesting for an actual image please make sure to fill out the Authorization Form MR-4775) The form may be accessed at the following web site:** http://ozone.ohsu.edu/healthsystem/HIS/mr4775.pdf

- Labs – all laboratory test results
- ED – Emergency Department reports by physician
- Billing – Hospital and / or clinic billing information
- Immunizations – all immunization records
- Other – Specify information not listed

OHSU OUTPATIENT PRACTICES/CLINICS:

Adult Psychiatry
Allergy & Immunology
Anticoagulation
Audiology
Bone & Mineral
Bone Marrow Transplant / Leukemia
Cardiology
Casey Eye Institute
CDRC Eugene
Center for Women's Health
Child and Adolescent Psychiatry
Childhood Development and Rehabilitation (CDRC)
Comprehensive Pain Center
Dermatology
Dermatology Surgery
Diabetes
Digestive Health
Doernbecher Pediatrics - Westside
Employee Health
Endocrinology
Executive Health
Family Medicine at South Waterfront
Gabriel Park
Gastroenterology
General Pediatrics
General Surgery
GI / Hepatology
Health Promotion and Sports Medicine
Hematology / Oncology
Infectious Disease
Intercultural Psychiatry Program
Internal Medicine
Knight Cancer Center/Community Hematology Oncology
Lipids
Liver Transplant
Marquam Hill Internists
Nephrology & Hypertension
Neurology
Neurosurgery
Oral & Maxillofacial Surgery
Orthopaedics
Otolaryngology
Pediatric Hematology / Oncology
Pediatric Specialties
Perinatal
Plastic Surgery
Pulmonary
Radiation Oncology
Renal Transplant
Rheumatology
Richmond
Riverplace
Scappoose
Sleep Medicine
Surgical Oncology
Urology
Vascular Surgery