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)
AUTHORIZED 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: ________________________________________________________________
(Name of recipient)

____________________________  ______________________________  ______________________________  ______________________________
(Address of recipient)   (City)   (State)   (Zip Code)

Oregon Health & Science University Clinical Transplant Services
3181 SW Sam Jackson Park Road  Mailcode: CB560  Portland  OR  97239

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: ________________________________

ONLINE 6/12 (Supersedes 5/04) MR-1470
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