

OHSU Transplant Referral Form

Patient information

Patient name:

Date of birth:

Please evaluate patient for:

Kidney transplant Simultaneous pancreas and kidney transplant Simultaneous liver and kidney transplant

Please include the following records for all referrals:

Patient's most recent H&P (must be within the last 12 months) Patient's most recent renal function lab results Vaccine history

Please include the following for patients on dialysis:

Medicare 2728 (if on dialysis) Rounding Report or Treatment Log (if on dialysis)

Dialysis type: Dialysis unit:

Please include the following for patients with prior transplant history:

Organ transplanted: Date of transplant:

Transplant center name:

Please check any of the following that apply to this patient being referred:

Does not want a transplant referral Has active cancer Is a resident of a long term care facility or is in hospice

Other (explain below)

Insurance information

Primary insurance:

ID #:

Subscriber:

Group #:

Secondary insurance:

ID #:

Subscriber:

Group #:

Medicare Part D ID:

Group #:

Bin:

Phone no.:

If we have questions or need additional information, please include contact information for referring clinic (nephrology or dialysis):

Name:

Phone no.: