



Jacksonville Transplant Center  
580 West 8<sup>th</sup> Street, Suite 8000, T36  
Jacksonville, FL 32209  
Phone: (904) 244-9800 Fax: (904) 244-9842

### Kidney Transplant Referral Form

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle Maiden

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_ Height/Weight: \_\_\_\_\_ / \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Other: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance: Primary \_\_\_\_\_ Secondary: \_\_\_\_\_  
(Please provide copy of insurance card(s))

Referring Nephrologist: \_\_\_\_\_ Phone: \_\_\_\_\_

Nephrologist NPI #: \_\_\_\_\_ ESRD Diagnosis Date: \_\_\_\_\_

Dialysis Center: \_\_\_\_\_ Cause of ESRD: \_\_\_\_\_

Dialysis Center Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Dialysis Start Date: \_\_\_\_\_ Type of Dialysis: Hemo PD (Night cyclor or daily exchanges # \_\_\_\_\_)

Dialysis Days: \_\_\_\_\_ Time: \_\_\_\_\_ Length of Treatment: \_\_\_\_\_

Allergies:  
\_\_\_\_\_  
\_\_\_\_\_

Has the patient ever been evaluated for a kidney transplant or had a previous transplant? Yes No

If transplanted, type of transplant: \_\_\_\_\_ Transplant Center: \_\_\_\_\_

Date of transplant: \_\_\_\_\_

Please **COMPLETE** above information and attach the most recent reports on the following:

- |                             |                                |  |
|-----------------------------|--------------------------------|--|
| History and Physical        | Clinic Notes                   | Psychosocial Summary                     |
| Recent Laboratory Data      | Physician Notes                | Dietary Assessment/Notes                 |
| EKG                         | Cardiac Studies (if available) | Hepatitis Profile/HIV Reports            |
| Chest X-Ray                 | Transfusion History            | Copy (Front and Back) of Insurance Cards |
| List of Current Medications | PPD Results (if available)     |  |

Does patient have special needs (wheelchair, blind, etc.)? \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_