PRINT BLANK FORM | PRINT COMPLETED FORM AND RESET | RESET FORM

MUSC Health
TRANSPLANT CENTER

ASCREENCRIT

Referral for Renal / Pancreas Transplantation

Form Origination Date: 7/13
Version: 2
Version Date:3/14

Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

Complete and return to:
MUSC Transplant Program
162 Ashley Avenue, MSC 586
Charleston, SC 29425
Fax: 843-876-2968
Email: KidneyTransplant@musc.edu

Date: _____

Patient Name _____

Address: _____

Phone #: _____ Cell Phone #: _____

DOB: _____ Email Address: _____

Preferred Method of Contact: ☐ Mail ☐ Phone ☐ Email

Age: _____ Ht. (cm): _____ Wt. (kg): _____ Gender: _____ SS#: _____

Ethnicity:
☐ White
☐ American Indian/Alaska Native
☐ Hawaiian/Pacific Islander
☐ Asian
☐ Black/African American
☐ Hispanic/Latino
☐ Other: _____

Diagnosis: _____ Date of Dialysis Onset: _____

Dialysis Unit: _____ Dialysis Days: ☐M ☐T ☐W ☐Th ☐F ☐Sat ☐Peritoneal

Address: _____

Case Manager: _____ Email Address: _____

Phone: _____ Fax: _____

Diabetes? ☐ Yes ☐ No _____ Date/Age of Onset: _____ Insulin Dose: _____

Has patient ever had any of the following: heart attack, stroke, stent in the heart, or bypass? ☐ Yes ☐ No
Has patient had a previous transplant ☐ Yes ☐ No

Comments from **Nephrologist** concerning patient's candidacy for renal transplantation:

_____

_____

_____

Patient is: ☐ Excellent ☐ Good ☐ Marginal

Referral should include:
☐ Completed referral form
☐ Clinical Documentation (Most current H&P, labs and/or Discharge Summary)
☐ Copy of insurance cards (front & back)
☐ Medication list
☐ For HIV patient: Records from Infectious Disease, including: last 6 months of notes and HIV labs
☐ Copy of CMS Form 2728

Nephrologist Signature: _____

Nephrologist Printed Name: _____ Phone #: _____

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