EMORY TRANSPLANT CENTER

- ◯ Kidney
- ◯ Kidney/Pancreas
- ◯ Pancreas

Referral Date: _____

Referring Physician: _____

Practice Name: _____

Referring Address: _____

_____

Phone Number: _____

Fax Number: _____

Required Documentation

Fax Documents to: 404-727-8972

- ☐ Primary Insurance Cards: front & back copy
- ☐ Secondary Insurance Cards: front and back
- ☐ Form 2728
- ☐ H&P (within 6 months) - if not available, provide hospital discharge summary, admission H&P or last office visit note
- ☐ Recent Labs (within 3 months)
- ☐ Medication List
- ☐ Completed Referral Form

Patient Information

Last Name: _____

First Name: _____ MI: _____

SSN: _____

Street Address: _____

City: _____ State: _____

Zip: _____

Primary Phone: _____

Secondary Phone: _____

DOB: _____ Race: _____ Gender: _____

Email: _____ Occupation: _____

Language of Choice: _____ Translator? ☐ YES ☐ NO

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

Insurance Company: _____ Policy Number: _____

At which Emory clinic would the patient like to start the transplant evaluation? Please select preference:

Emory Main ☐ Athens ☐ Acworth ☐ Columbus ☐ Dublin ☐ Savannah ☐ Thomasville ☐

Medical Information

☐ Patient is not on dialysis

Dialysis Center: _____ CMS Number: _____

Phone: _____ Fax: _____

Type of Dialysis: ☐ Hemo ☐ Home Hemo ☐ Peritoneal CAPD ☐ Peritoneal CCPD

Schedule: ☐ (M/W/F) ☐ (T/Th/S) Dialysis start date: _____

Cause of Renal Failure/ Diagnosis: _____

Height: _____ Weight: _____

Completed by: _____ Phone: _____

Address: _____ Fax: _____

Once we receive all referral patient information requested on this form, the patient will typically be seen within 2-6 weeks.
We will notify the patient of appointment date/time, test results, treatment, diagnostic information.
We will provide visit notes to your office using the contact information provided on this form.