Ascension
Sacred Heart

CONSULT FORM FOR KIDNEY TRANSPLANT CANDIDATES
PLEASE PRINT CLEARLY AND FILL OUT COMPLETELY

Referring Provider: ______________________ **Person Initiating Referral:** ______________________

Origin of Renal Disease (attach Medicare Form 2728): ______________________

Patient Name (Last, First, MI): ______________________

DOB: __________ **Sex: M / F** **Race:** __________ **Height:** __________ **Weight:** ________ **BMI:** __________

SSN: __________ **Employed: Y / N** **Marital Status:** __________ **Spouse:** __________

Address: ______________________ **County:** __________

City: ______________________ **State:** ______________________ **Zip:** __________

Patient Contact Information

Home Phone: __________ **Work Phone:** __________ **Cell:** __________

Other: __________ **Email:** __________

Dialysis: Y / N

If YES->> Start Date & Type:______________________ **Schedule (circle): Su M T W Th F Sa**

Previous Transplants: Y / N

If YES->> Date of Transplant:_________**Organ:**___________**Transplant Center:**______________

Does Patient have a potential LIVING DONOR: Y / N

Has Patient Been referred/activated at any other transplant center(s): Y / N

If YES, where? ______________________

Dialysis Unit or Referring Office Information

Facility Name: ______________________ **Contact Person & Phone:** ______________________

Facility Address: ______________________

Facility Phone: ______________________ **Facility Fax:** ______________________

THE FOLLOWING ATTACHMENTS ARE MANDATORY:	***Send if reports are available:***
➢ ***Medicare Form 2728*** ➢ **Copy of Insurance** (*front & back & pre-authorization)* ➢ **History and Physical** (*within the past 12 months)* ➢ **Current lab work** (*within the past 6 months*)	____Stress Test ____ECHO ____Pap / pelvic exam ____ ____Mammogram ____Peripheral Vascular Studies ____Colonoscopy Report with pathology ____Imaging studies of chest/abd/pelvis

The patient will be contacted regarding scheduling an appointment after referral is received.
We look forward to meeting your patient and the opportunity to work with you.

MAIL/FAX COMPLETED FORM & ATTACHMENTS TO:

Sacred Heart Kidney Transplant
5149 N 9th Ave, Suite 246
Pensacola, FL 32504
Phone: 850-416-1080 Fax: 850-416-1075