UCI Health

NEW TRANSPLANT PATIENT REFERRAL
(Please check all that apply)
☐ Kidney Transplant
☐ Kidney/Pancreas Transplant
☐ Pancreas Transplant

A COMPLETE REFERRAL INCLUDES THE FOLLOWING:
History & Physical that states cause of ESRD,
CMS-2728 Form, Medication List, Most Recent Labs

PLEASE FILL OUT COMPLETELY AND FAX TO 888-972-2110

PATIENT INFORMATION - PLEASE SEND COPY OF PATIENT IDENTICATION (DRIVERS LICENSE OR PASSPORT & SOCIAL SECURITY CARD

Patient Name:	Language Spoken:
Date of Birth: Sex: ☐ Male ☐ Female	Emergency Contact Name:
Social Security #	Emergency Contact Phone:
Maiden Name:	Relationship to Patient:
Street Address:	Citizenship Status:
City State: Zip:	Have you ever been seen at UCI: Y / N DATE:
Phone (H): (C):	Ethic Background:
Email:	Marital Status:

INSURANCE INFORMATION - PLEASE SEND COPY OF INSURANCE CARDS (Front and back with legible member ID#)

Primary Insurance Carrier:	**Secondary Insurance Carrier:**
Member ID#	Member ID#
Guarantor:	Guarantor:
Insured SSN# Insured DOB:	Insured SSN# Insured DOB:

CLINICAL INFORMATION

Cause of Renal Failure:	HT:	WT:	BMI:
Dialysis: ☐Pre-dialysis ☐ Hemodialysis ☐CAPD/CCPD	Past Medical History:		
Original Dialysis Start Date:			
Dialysis Treatment Days: ☐ M/W/F ☐ T/TH/S ☐ Other :_ Time/Shift:	Past Surgical History:		
Previous Transplant: ☐ YES ☐ NO Organ: Date: Center:	Multi-Listed: ☐ YES ☐ NO Center:	History of Mental Illness:	
Currently Smoking: ☐ YES ☐ NO Packs per day?	Drug Use: ☐ YES ☐ NO Type:	Drinking: ☐ YES ☐ NO Frequency:	
Recent Hospitalizations:	Recent Testing/Location:		
Does Patient Have a Potential Living Donor? ☐ YES ☐ NO ☐ UNSURE			
Relationship To Donor:			

DIALYSIS CENTER / REFERRING PHYSICIAN

Dialysis Center:	Referring MD:
Street Address:	Street Address:
City State: Zip:	City State: Zip:
Phone:	Phone:
Social Worker:	Fax: