Kidney/Pancreas Transplant Referral

Mailing Address:
1120 15th Street, AD-3401
Augusta, GA 30912

T (706) 721-2888
F (706) 721-6271 referrals
augustahealth.org

AUGUSTA UNIVERSITY Transplant Program

REQUIRED DOCUMENTS FOR PROCESSING

❑ **Insurance Cards** *(legible copy, front and back)* ❑ **H&P within the past 12 months** ***If on dialysis:***

❑ **Driver's License or State Issued ID** ❑ **Recent Medication List** ❑ **Form 2728**

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

REFERRAL INFORMATION

Referring Physician: _____ Phone: _____

Dialysis Center: _____ Phone: _____

Initial Dialysis Date: _____ Type of dialysis: ❑ HD ❑ PD ❑ Home HD

Hemodialysis Schedule: ❑ Mon-Wed-Fri ❑ Tu-Thu-Sat ❑ Nocturnal Other: _____

Form Completed By: _____ Date: _____ Phone: _____

INSURANCE INFORMATION

❑ Medicare ❑ Medicaid ❑ VA ❑ Commercial

Primary Insurance: _____ Prescription Plan: _____

Secondary/Tertiary Insurance: _____

Estimated years of employment: _____ ❑ Working ❑ Not Working ❑ Retired

MEDICAL INFORMATION

Cause of renal failure (primary diagnosis): _____

Measured, without shoes Height (cm): _____ Weight (kg): _____ BMI: _____

❑ Patient in evaluation or listed at another transplant center

If yes, where _____

❑ Patient exhibits compliance concerns

If yes, specify _____

Remarks or reservations regarding referral:

Does the patient exhibit or have a history of:

❑ Diabetes
❑ Previous transplant *If yes, specify* _____
❑ Active infectious disease (HIV, Hepatitis B or C, ongoing infection)
❑ Autoimmune disease
❑ Heart attack, stroke, stent in heart, or bypass
❑ Malignancy *If yes, specify* _____
❑ Sensory deficit (blindness, hearing loss)
❑ Severe pulmonary disease
❑ Active alcohol or substance abuse
❑ Smoking

FOR AU TRANSPLANT CENTER USE Received by: _____ Date/Time: _____