University Health

PEDIATRIC KIDNEY TRANSPLANT REFERRAL FORM

Please Fill Out The Information Below:

Child's Name:_____

Date of Birth:_____

Social Security Number:_____

Address:_____
(Street)

_____
(City/State/Zip)

Guardian Name: _____

Phone Number:_____

Gender: ❑ Male ❑ Female

Language: ❑ English ❑ Spanish Other:_____

Primary Insurance:_____

Secondary Insurance:_____

Patient Information

ESRD (Renal Disease) due to:_____

Height: _____Weight:_____ BMI:_____

Treatment Modality: ❑ HD ❑ PD ❑ Pre-Dialysis

Days & Shift:_____

1st Date of Dialysis:_____

Referring Physician Information

Name:_____

Specialty:_____

Dialysis Center:_____

Address:_____
(Street)

_____
(City/State/Zip)

Phone:_____ Fax: _____

Office Contact:_____

Email:_____

Assessment of patient from referring nephrologist:

❑ Excellent ❑ Good ❑ Marginal ❑ Unacceptable

Date of Referral:

Month	Day	Year

❑ Consult for Kidney Transplant Evaluation

List of Possible Living Donors

Name/Relationship: Phone:

_____

_____

_____

Primary Caregiver Information

Caregiver Name:_____

Home Phone:_____

Cell Phone:_____

Work Phone:_____

E-mail:_____

Please fax the following information with this form:

- ❑ Patient's demographic form
- ❑ ESRD form 2728
- ❑ Current History and Physical (less than 12 months old)
- ❑ Current Medication List
- ❑ Current PPD results (less than 12 months old)
- ❑ Labs from outside facilities (genetics testing, any past ABO report)
- ❑ Copy of insurance
- ❑ Radiology tests from outside facilities (ECHO, EKG, Renal Ultrasound, or Renal scan)
- ❑ Current Immunization Record
- ❑ Social Assessment
- ❑ Dietary Assessment
- ❑ Renal Ultrasounds and/or Renal Biopsies (if available)
- ❑ Copy of caregiver's driver's license
- ❑ Copy of patient's social security card

Contact Information:

Referral Hotline
210-567-5777 or
888-336-9633

Referral Fax
210-358-0408 or
210-702-4131

Referral Address
4502 Medical Dr., MS 18 • San Antonio, TX 78229

UniversityTransplantCenter.com/referral