Ochsner
Multi-Organ Transplant Institute

# Referral Form for Kidney, Kidney/Pancreas and Pancreas only

**Referrals are processed once all requested information is received**
**Fax: 504-842-3343 Phone: 504-842-3925**

**PLEASE ATTACH THE FOLLOWING PRIOR TO SENDING REFERRAL:**

- ☐ **Completed Referral Form**
- ☐ **Patient Demographic Sheet**
- ☐ **Copy of insurance cards front and back**
- ☐ **Complete History & Physical (within 1 year of referral date)**
- ☐ **Medicare Form 2728 (if on dialysis), patient cannot be listed without this**
- ☐ **Medication List**
- ☐ **Lab results/TB skin test (within 1 year of referral date)**
- ☐ **PTH < 1000 to be considered for transplant**

**PATIENT INFORMATION:**

NAME: Last: _____ First: _____ MI: _____

DOB: _____ SSN: _____ Race/Ethnicity: _____ Gender: _____

Phone: _____ Cell: _____

**REFERRING PHYSICIAN INFORMATION:**

Name: _____ Email: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____ Fax: _____

**DIALYSIS INFORMATION: NOT ON DIALYSIS / CYCLER PD / CAPD / HEMO**

Dialysis Schedule: **Home / MWF / TTS**

Initial Dialysis Start Date: _____

**Dialysis Unit Name:** _____

Address: _____ State: _____ Zip code: _____

Phone: _____ Fax: _____

Nurse: _____ Social Worker: _____

**REQUIRED FOR PRE-SCREENING:**

- ☐ Age: _____ Height (ft & in): _____ Weight (lbs.): _____ BMI: _____
- ☐ History of malignancy? **Y/ N** If yes, please explain: _____
- ☐ Active systemic infection? **Y/ N** If yes, please explain: _____
- ☐ Hepatitis? **Y/ N** If yes, please explain: _____
- ☐ HIV? **Y/ N** If yes, provide record of CD4 counts & HIV viral load (last 6 months)

**Patient Name:** _____ **D.O.B.:** _____

Is the patient diabetic? **Y / N** If yes, age diagnosed? _____ On Insulin? **Y / N**

Tobacco Use? **Y/ N** Does the patient have a living kidney donor? **Y / N**

Referred for transplant evaluation due to **renal failure diagnosis of**: _____

**To expedite your referral, please send the following clinical information from the past 12 months, if available:**

- ☐ Immunization History
- ☐ Hepatitis B & Hepatitis C results
- ☐ ABO typing results
- ☐ Any diagnostic studies (cardiac stress testing, cardiac catheterization, echocardiogram, radiological examinations, & renal biopsies)
- ☐ Colonoscopy (>50 years old; or >45 years old if African American)
- ☐ Females: Updated PAP Smear & Mammogram (>40 years old)

**PSYCHOSOCIAL HISTORY: (attach psychosocial evaluation, if available)**

Any mental health history, substance use or other issues which may impact outcomes of kidney transplant or which may be relevant to our evaluation? **Y / N** If yes, please describe: *(attach additional pages as needed)*

**Transportation:**

- ☐ Never / Rarely has difficulty with transportation to dialysis
- ☐ Misses treatments due to lack of transportation
- ☐ Type of transportation: (Medicaid, family, etc.) _____

**Compliance (last 3 months):**

- ☐ Takes medicines as directed
- ☐ Misses medicines frequently / often
- ☐ Completes dialysis as directed
- ☐ Misses treatments: ___ times per month
- ☐ Signs off early from dialysis ___ times per month

**Caregiver:**

- ☐ Caregiver's name: _____

**Finances (last 3 months):**

- ☐ Has difficulty making ends meet or cannot afford costs of daily living
- ☐ Has stopped taking medications before due to inability to pay
- ☐ Patient receives AKF ins. premium assistance?

**Special Needs:**

- ☐ Blind/Sight limited
- ☐ Unable to read
- ☐ Interpreter
- ☐ Deaf/Hard of hearing
- ☐ Prosthesis
- ☐ Wheelchair
- ☐ Walker
- ☐ Oxygen

Is patient aware they are being referred for transplant? **Y / N** _____

Is patient listed at another transplant center? **Y / N**: **Willis Knighton / Tulane / Outside of LA:**

If listed outside of Louisiana, indicate name of Transplant Center: _____

***Please Note:*** ***ALL patients are required to bring their adult caregiver/ support person (> 18 years old) for transplant evaluation appointments or the patient will not be seen when they arrive. Caregivers play a vital role in transplant.***