RESEARCH MEDICAL CENTER TRANSPLANT INSTITUTE

REFERRAL FORM

COMPLETE AND FAX BACK TO 816-276-4857 OR
CALL TO MAKE REFERRAL: FOR KC AT (816) 822-8257 FOR WICHITA AT (316) 962-6351

Name:___________________________________ DOB:_______________________________

Address:_________________________________ Kidney_________ Pancreas __________

City/State/Zip:_____________________________ SSN: _______________________________

Home/Cell Phone:___________________________ Diabetic: Y N Type:_____________

E-Mail address:_____________________________ Height ___________Weight____________

Does patient have a living donor: ___ yes ___ no Name/Relationship _________________________

Has patient ever been evaluated for a transplant at any other center? _____ yes _____ no

(If yes) Name of Transplant Center _________________________ Date of Eval _________________

Was patient listed for a transplant there? ___yes ___no (If no) Reason denied _______________

Previous transplant: ____Yes ____No How many:_________ Where:__________________________

RENAL INFORMATION

Nephrologist:_____________________ Address/Phone:____

Dialysis Unit:_____________________ Date Started: _________ Address/Phone:___________________

Modality: Hemo___ PD___ Home ___ Schedule: M-W-F______ T-TH-S________ Other _________

INSURANCE INFORMATION (Include Copies of Insurance cards with Referral)

Primary Ins: __________________ID#:______________________ Phone#:_______________________

Is this a: Medicare Replacement ____ Marketplace Plan____ Emp. Group Health____ Private____

Premium paid by: Self ____ Employer:_______________________ Other: ________________________

Medicaid Spend Down: Y N How Much:_______________ Medicare Cost:_________________
Policy Holder
_______________________DOB____________SS#___________________EMPLOYER_________________

Secondary Ins: ________________ ID#_______________________ Phone#:_______________________

Is this a: Medicare Sup.____ Medicare Replacement____ Emp. Group Health____ Private______

Premium paid by: Self ____ Employer:_______________________ Other: ________________________

Medicaid Spend Down: Y N How Much:_______________ Medicare Cost:_________________
Policy Holder
_______________________DOB____________SS#___________________EMPLOYER_________________

9/1/17