

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 _____