Kidney/Pancreas Transplant Referral Application

Date: ◯ **Kidney** ◯ **Pancreas** ◯ **Kidney and Pancreas** ◉ **Retransplant**

If patient's demographic form is not available, please fill out the following information:

Name:

Date of Birth: ◯ Male ◯ Female Marital Status:

Address:

City: State: ZIP:

Home Phone: Mobile Phone: Work Phone:

Language Preference: ◉ English ◯ Spanish Other

Email:

Primary Insurance: Secondary Insurance:

Please notify the Primary Care Physician (PCP) of this referral, if required by the insurance company.

REFERRING PHYSICIAN INFORMATION:

Referring Physician: Specialty:

Dialysis Center:

Address:

City: State: ZIP:

Dialysis Phone: Office Fax: Office Contact:

PATIENT INFORMATION:

Dialysis days and shift: First day of chronic dialysis:

Treatment modality: ◯ HD ◯ PD ◯ Pre-Dialysis

Any known allergies: Height: Weight: BMI:

IMPORTANT! **Please fax the following information with this form:**

- Patient's demographic form
- Copy of insurance cards (front and back)
- Recent history and health physical
- Current medication list
- Immunization records
- Form 2728, if applicable

The patient will be contacted within 72 business hours by phone or email to confirm that we have received your referral.

NOT PART OF PATIENT MEDICAL RECORD

Intake Coordinator: 713.704.6806 or 713.704.6808
Referring Hotline: 713.704.5200 or 800.869.5996
Referring Fax: 713.704.0081
Referring Address: Memorial Hermann-Texas Medical Center
6411 Fannin St., Suite J1-400, Houston, TX 77030

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