Dialysis Unit: ______________________
Designated: ______________________
Referral Date: ______________________

Kidney and Kidney/Pancreas
Transplant Referral Form
Vía Fax: 787-771-7395 or Email: referidospretrasplante@auxiliomutuo.com

Instructions:

To begin our assessment, the following information is required. Please use the form to ensure **ALL REQUIRED** documents are received. Please send patient's records and demographics (**including a copy of the insurance card**). **Any incomplete or missing information will result in the referral being delayed.**

If the patient presents any of conditions of exclusion **(not interested in transplantation; chronic infection; HIV+; BMI >35; terminal lung disease; alcohol use; drugs and active smoker)**, it is understood that **NOT** currently a candidate for referral to the Transplant Center**. It is not necessary to send the referral.**

I. Patient Information

Legal Name: ______________________________________ Gender: ☐ Male ☐ Female
(first, middle, last name)

Mailing Address: ____
____
____

Date of birth: _____/_____/______ (M D Y) Age: _________ SS#: _____-_____-_____

Marital status: ☐ married ☐ single ☐ divorced ☐ widowed

Allergies:____

Telephone numbers: home: (_____) -__________________; cell- (_____) -__________________

work- (_____) -__________________

Visual impairment: ☐ Yes ☐ No Hearing impairment: ☐ Yes ☐ No

Need Sign language interpreter: ☐ Yes ☐ No

Education completed: ☐ Elementary ☐ Intermediate/High School

☐ College ☐ Graduate ☐ N/A

Family Support: ☐ Yes ☐ No Facility of Transportation: ☐ Yes ☐ No

Height: ________ **weight:** _______ **BMI:** _________ **Dietitian Name:** ______________________

II. Health Insurance

Primary Insurance: __________________ Secondary Insurance: _________________

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AUXILIO CENTRO DE TRASPLANTE

Dialysis Unit: ______________________
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III. Referring Physician

Physicians:

Primary Care Name: _______________________ Telephone #: (_____) -______-__________

Nephrologist Name: _______________________ Telephone #: (_____) -______-___________

IV. Medical History (Please answer the following by putting a check mark in the appropriate box)

	Yes	No		Yes	No
High Blood Pressure	☐	☐	Diabetes: Does patient use insulin?	☐	☐
Heart Disease Last Consult of Cardiology: _____________________	☐	☐	Seizure Disorders: Is patient on medication? Name of medication: ___________________	☐	☐
Cardiac Pacemaker	☐	☐	Hepatitis A was it treated?	☐	☐
Stroke: Vascular Disease	☐	☐	Hepatitis B was it treated?	☐	☐
Stomach Ulcer	☐	☐	Hepatitis C was it treated?	☐	☐
High Cholesterol	☐	☐	Hepatitis A was it treated?	☐	☐
Sleep Apnea	☐	☐	Hepatitis B was it treated?	☐	☐
Asthma/Lung Disease	☐	☐	Hepatitis C was it treated?	☐	☐
Tuberculosis	☐	☐	Hepatitis A was it treated?	☐	☐
Bedridden	☐	☐	Wheelchair	☐	☐
Amputations	☐	☐	Ulcers or wounds?	☐	☐
Antibiotics at present?	☐	☐			

History of Cancer? ☐ Yes ☐ No
If Yes, what type? ____
Date of Diagnosis? ____
Type of treatment? ____
Oncologist Name_____________________________ Telephone #: (_____) -______-__________

Last Hospitalization: _______________________ Surgery Interventions:________________________

Blood Transfusions? ☐ Yes ☐ No

Is patient a current smoker? ☐ Yes ☐ No If no, did patient ever smoke? ☐ Yes ☐ No

If Yes, how many packs per day? ___________ For how many years? ___________

Does patient use alcohol? ☐ Yes ☐ No If Yes, how often? _____________

Has patient ever used recreational drugs? ☐ Yes ☐ No

Is patient currently using these? ☐ Yes ☐ No

Name(s) of recreational drugs used: ____

Does patient take medication for anxiety or depression? ☐ Yes ☐ No

Name of Medication(s): ____

Is patient currently under the care of a Psychiatrist or Psychologist? ☐ Yes ☐ No

Name of your Psychiatrist or Therapist: ______________ Telephone #: (____) -_____-__________

Social Worker Name: ____________________

V. Kidney Disease History:

What is the cause of kidneys failure?

DM ☐ HTN ☐ PCKD ☐ Glomerulonephritis ☐ Unknown ☐ Other: ☐ ______________

Have you started dialysis? ☐ Yes ☐ No

If Yes, when did you start? Date: ____________________

Type of dialysis? ☐ Hemodialysis at a Center ☐ Hemodialysis at home Peritoneal

Treatment Days: ____________ Time: ______________

Have you ever had a kidney biopsy? ☐ Yes ☐ No

Have you had a kidney transplant? ☐ Yes ☐ No If Yes, how many? _________

Vascular access problem? ☐ Yes ☐ No

VI. Medical Record Checklist:

<u>YOU MUST SUBMIT ALL REQUIRED ITEMS LISTED BELOW:</u>

- ☐ **Recent Dictated (Typed) History and Physical from referring Nephrologist**
- ☐ **Nephrologist Progress Notes**
- ☐ **Dialysis Progress Notes (Required only for patients on dialysis)**
- ☐ **Dialysis Social Worker Assessment (Required only for patients on dialysis)**
- ☐ **Recent Laboratory Results from Nephrologist clinic or Dialysis Center**
- ☐ **Copy of CMS 2728 Form (Required only for patients on dialysis)**
- ☐ **Legible copy of your Driver's License or valid identification**
- ☐ **Legible copy of insurance cards (front and back)**
- ☐ **Pathology reports and medical records (Required for all patients with a reported history of cancer)**