**New Referral Checklist**

To facilitate the referral process for a Transplant Evaluation the following data is requested.

 **Physician Attestation**: I am recommending this patient for kidney transplant evaluation at VTC based on referral criteria below and certify that he/she meets the condition of medical necessity for transplantation.

Nephrologist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of referring Nephrologist** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please fax documents to:** Trish Hughes, Office Coordinator

 7605 Forest Ave. Suite 303

 Richmond, VA 23229

 (804) 289-4941 (Phone)

 (804) 287-4359 (Fax)

**Patient Meets ALL of the Following Criteria:**

1. Demonstrates compliance with treatment plan and medications.
2. BMI of 40 or less.
3. NO evidence of the following barriers to transplant:
	1. Uncorrectable Cardiac disease
	2. Uncorrectable Pulmonary Disease and/or O2 Dependent
	3. Chronic infection unresponsive to treatment
	4. Active Substance Abuse
	5. HIV Positive
	6. ACTIVE Cancer
	7. Major psychiatric disorder that is unstable despite medical management
	8. Insufficient financial or social resources to support long term transplant care

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE Send the following patient information with this referral:**

**SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ (\*required for registration)**

1. Demographics Sheet: Phone, address, DOB
2. COPY of 2728 Medical Evidence Report (IF patient is on dialysis)
3. COPY of patient insurance card(s) **and** Rx card(s)
4. Current Height: \_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Latest MD office/Progress Notes/H&P/Discharge Summary
6. Latest RD **and** SW assessment notes.
7. Medication List
8. Latest Labs
9. Copy of any ***immunization records*** (esp. HBV vaccine)
10. PPD Results
11. Modality: (circle one)
	1. PRE Dialysis
	2. Peritoneal Dialysis
	3. HEMODialysis
12. Dialysis Shift (circle):
	1. Day (circle): MWF **OR** TTS
	2. Shift (circle): Morning Afternoon Evening
13. DIAGNOSTICS:
	1. EKG
	2. Chest X-Ray
	3. Cardiology Tests: ECHO and/or Stress Test and/or CATH
	4. Pap/Mammogram
	5. Colonoscopy
14. IS patient receiving AKF premium assistance, RX grants or any other financial assistance? YES NO Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_