975 East Third Street, Suite B-1105
Chattanooga, TN 37403
Phone: (423) 778-8067
Fax: (423) 778-6674

# UT Erlanger Kidney Transplant Center Referral Form

**PATIENTS NAME:** _____ **DOB:**_____/_____/_____
Last First Middle

**ADDRESS:** _____ **TELEPHONE :**( H) _____
_____ (W) _____
_____ (Cell) _____

**SOCIAL SECURITY #:** _____ OTHER _____

**REFERRING NEPHROLOGIST:** _____ **TELEPHONE:** _____

**ADDRESS:**_____ **FAX:** _____

**INSURANCE:** Primary_____Secondary: _____

**ETIOLOGY OF RENAL FAILURE**: _____

**DIABETIC:** Y/N _____ Age Onset _____ **HEIGHT**_____**WEIGHT** _____

**DIALYSIS INITIATION DATE:**_____**OR LAST CREATININE CL:**_____**DATE:**_____

**DIALYSIS CENTER:**_____**TELEPHONE:** _____

**ADDRESS:**_____**FAX:** _____

**DIALYSIS TYPE:** HEMO_____Dialysis Days:_____PD_____No Dialysis_____

**PRIOR TRANSPLANT:** Y/N (DATE)_____Transplant Center: _____

**IS THE PATIENT LISTED AT ANOTHER TRANSPLANT CENTER?** Yes_____No _____
Listed at: _____

**DOES THE PATIENT HAVE A HISTORY OF: (IF YES INDICATE TREATMENT RECIEVED)**
Coronary Artery Disease: Y/N _____
Peripheral Vascular Disease: Y/N _____
Cancer: Y/N Type_____
Substance Abuse: Y/N Type_____
Hepatitis: Y/N Type_____Treatment_____
Compliance Issues: Y/N T y p e _____

**PLEASE INCLUDE THE FOLOWING WITH REFERRAL:**
____Patient Demographic Sheet **(Required)**
____Copy of Insurance Cards **(Required)** Premiums paid for by AKF ☐ Yes or ☐ No
____Recent History & Physical
____Medication List
____TB results & most Recent LAB
____Psychosocial & Nutrition Evaluation
____2728 Form (**Required**, if ESRD on dialysis)
____Renal Biopsy (if done)
____Any Previous Test Results (EKG, STRESS TEST, ECHO, CATH, CT, CXR …etc)

****SIGINATURE/ STAMP OF REFERRING PHYSICIAN OR NP:**_____**Date:** _____

If you have any questions, concerns or issues you wish to discuss, please call
Erlanger's Transplant office at (423) 778-8067
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