

**Lahey Hospital & Medical Center: Kidney Transplant Referral Form**

Thank you for choosing Lahey. We look forward to partnering with you in your patient's care.

Date: \_\_\_\_\_ # of pages faxed: \_\_\_\_\_

**Patient Information:**

Last name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ MRN: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ Gender:  M  F Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Needs Interpreter:  Yes  No Language: \_\_\_\_\_

Medical Insurance: \_\_\_\_\_

Cause(s) of renal failure: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_

Next of kin and phone number: \_\_\_\_\_

**Referring Provider Information:**

Referring MD: \_\_\_\_\_ Medical Group: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Is referring provider patients PCP?  Yes  No

If no, please list PCP: \_\_\_\_\_

**Dialysis Information:**

On Dialysis?  Yes  No If yes:  Hemodialysis  Peritoneal Dialysis  Home Dialysis

Dialysis Center Name: \_\_\_\_\_

Dialysis Center Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Dialysis Center Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Date of 1<sup>st</sup> Dialysis: \_\_\_\_\_

Dialysis days:  MWF  TTS  Other Dialysis Time Slot: \_\_\_\_\_

Previous Transplant:  Yes  No If yes, where? \_\_\_\_\_

**Required Documents. Please send ASAP. Missing documents may result in delayed scheduling. Fax to: 833-461-0694**

- 2728 form (if on dialysis)
- Recent bloodwork
- Recent Nephrology Note
- Medication list and Immunization record
- Recent testing/imaging

**For internal use only:**  Spoke to Patient  Appointment Made  Missing documents