Phone: 781-744-2500 Fax: 1-833-461-0694

Beth Israel Lahey Health
Lahey Hospital & Medical Center

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: _____

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: _____

Patient Information:

Last name: _____ First Name: _____ MI: _____

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: _____

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 1st Dialysis: _____

Dialysis days: ☐ MWF ☐ TTS ☐ Other Dialysis Time Slot: _____

Previous Transplant: ☐ Y es ☐ 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