Kidney and/or Pancreas Transplant
Physician Referral Form

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

This referral form is to request a **pre-transplant evaluation** for potential kidney and/or pancreas transplant.
If this referral is for post-transplant follow-up, please call 614-293-8746 for assistance.

Updated 2/22/2023

Please fill out this form completely, include any clinical documentation relevant to this referral, and fax all documents to **614-293-6710**.
Mail any additional imaging CDs and/or documentation to: **300 W. 10th Ave., 11th Floor, Columbus, OH 43210**.
To speak with a kidney transplant coordinator, call **800-293-8965**.

○ **Clinical Documentation included**
(Examples include: insurance cards, imaging, lab work, office procedures, office notes, etc.)

Patient Information:

First Name: | Middle Name: | Last Name:

Gender: | Marital Status: | Last 4-digits SSN#: | Date of Birth (mm/dd/yyyy): | BMI:

Primary Phone: | Email: **(required for virtual education)** | Primary Insurance: | Secondary Insurance:

Street Address:

City: | State: | Zip: | Country:

Details:

Primary Cause of Kidney Failure: | Height: | Weight:

Patient on dialysis? ○ Yes ○ No Dialysis start date (current center): | If no, patient's GFR?

Has a 2728 Form been completed? ○ Yes ○ No ***If complete, please include with this referral.***

Dialysis Center: | Dialysis Phone: | Dialysis Fax:

Any issues with patient adherence to treatment? ○ Yes ○ No

Does patient agree to receive blood products? ○ Yes ○ No

Is the patient aware of being referred to see the transplant specialist? ○ Yes ○ No

Referring Provider Information:

Provider First Name: | Provider Last Name: | NPI Number:

Street Address: | City: | State:

Zip: | Phone: | Extension: | Fax:

Physician Signature: ______________________ Date: ______________

Kidney, Kidney-Pancreas Transplant

Physician Referral Form

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Patient Name: ______ Date: ______

Medical History:

	Yes	No	Date	Diagnosis	Comments
Cancer	○	○			
HIV	○	○			
Cardiovascular Disease	○	○			
Diabetes	○	○			
Pulmonary Disease	○	○			
Active Untreated Systemic Infection	○	○			
Non-Healing Wound	○	○			
Substance Use Disorder	○	○			
Psychiatric Illness	○	○			

Required for Initial Referral:

Below documents are required for initial referral:

1) Medicare 2728 form, if on dialysis
2) Demographics sheet with current insurance information (or clear copy of insurance card – front and back)
3) Current history and physical within the past 12 months
4) Missed or Shortened Treatment reports for the past 6 months, if applicable

If available, to expedite referral, please provide below information:

1) Recent stress test (less than one year ago)
2) Recent cardiac echo (less than one year ago)
3) Recent labs
4) Psychosocial evaluation

Form will be returned if incomplete information is provided.

Patient will be contacted regarding scheduling of an appointment after complete referral is received.

Person Completing Form: ______