METHODIST UNIVERSITY HOSPITAL TRANSPLANT INSTITUTE
IN PARTNERSHIP WITH THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER
Kidney/Pancreas Transplant Referral Form

Mail or Fax the form as follows:
Methodist University Hospital Transplant Institute
1265 Union Avenue - 1 Sherard
Memphis, TN 38104
FAX: 901-516-2424
PHONE: 901-516-2396 or 901-516-2113

Required Information:
- ❑ Copy of Insurance Card (BACK and FRONT)
- ❑ Demographic information below **OR** printed demographic sheet attached
- ❑ List of medications
- ❑ Office notes, recent chest x-rays, EKG's, and current labs
- ❑ Psychosocial Evaluation by the Social Worker

Demographics

Patient Name:	Referral date:
Address:	Referring Physician:
City/State:	Referring Physician phone:
Zip:	Dialysis Center:
Patient Phone:	Dialysis Center Phone Number:
Pager/Cell Phone	Initial Dialysis Start Date:
SSN:	Dialysis Type:
DOB:	Dialysis Treatment Days:
Current Weight:	Patient has Access Problems: Yes or No
Current Height:	Patient has a Living Donor: Yes or No

Diagnosis

ESRD 2°:	Other:

Medical History

Cancer (Date and Type):
Cardiac Disease:
Pulmonary Disease:
Hepatitis Status/ HIV Status:
Substance Abuse:
Surgical History:
Previous Transplant: Yes or No Cause of Previous Transplant Failure:

Completion of this form constitutes a referral for transplant evaluation.

_____Signature (must be MD or NP) **Date_____**

_____Physician ID #

Last Updated: 03-27-06