Kidney Transplant Referral

THE University of Vermont MEDICAL CENTER

Mailing Address:
1 S. Prospect Street
Burlington, VT 05401

T (802) 847-4774
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REQUIRED DOCUMENTS FOR PROCESSING

- ❑ **Insurance Cards** *(legible copy, front and back)*
- ❑ **H&P within the past 12 months**
- ❑ **Recent labs with estimated GFR**
- ❑ **Recent Medication List**

If on dialysis:

- ❑ **Form 2728**
- ❑ **Vaccination Records**
- ❑ **Most Recent Care Plan**

SPECIAL ACCOMMODATIONS

- ❑ **Wheelchair/Mobility Assistance**
- ❑ **Interpreter Services**
- ❑ **Language** _____
- ❑ **PD exchange**

PATIENT INFORMATION

Last Name:_____ First Name:_____ Middle:_____

Date of Birth:_____ SSN:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Mobile Phone:_____ Work Phone: _____

Gender: ❑ Male ❑ Female ❑Other Race: _____

REFERRAL INFORMATION

Primary Care Provider: _____ Address: _____ Phone: _____

Referring Physician:_____ Address:_____ Phone:_____

Dialysis Center:_____ Address:_____ Phone:_____

Initial Dialysis Date:_____ Type of dialysis: ❑ HD ❑ PD ❑ Home HD

Schedule: ❑M-W-F ❑ Tu-Thu-Sat ❑ Nocturnal Other:_____

Form Completed By:_____ Date:_____ Phone: _____

INSURANCE INFORMATION

❑ Medicare ❑ Medicaid ❑ VA ❑ Commercial

Insurance Company:_____ ❑ Cobra Plan ❑ Premiums Paid by AKF

Policy Holder:_____ Policy Holder's relationship to patient: _____

Policy ID and suffix:_____ ❑ Working ❑ Not Working ❑ Retired

MEDICAL INFORMATION

Cause of renal failure (primary diagnosis): _____

Measured, without shoes Height (cm):_____ Weight (kg): _____ BMI: _____

Nicotine Use ❑Current ❑Past Quit date _____

❑ Patient in evaluation or listed at another transplant center
If yes, where _____

❑ Patient exhibits compliance concerns
If yes, specify _____

Remarks or reservations regarding referral:

Does the patient exhibit or have a history of:

- ❑ Diabetes *If yes,* ❑*Type I* ❑*Type II*
- ❑ Previous transplant *If yes, specify*_____
- ❑ Active infectious disease (HIV, Hepatitis B or C, ongoing infection)
- ❑ Autoimmune disease
- ❑ Heart attack, stroke, stent in heart, or bypass
- ❑ Neurological impairment
- ❑ Malignancy *If yes, specify*_____
- ❑ Sensory deficit (blindness, hearing loss)
- ❑ Severe pulmonary disease
- ❑ Active alcohol or substance abuse
- ❑ Covid Vaccine