THE University of Vermont MEDICAL CENTER

Living Donor Referral Form

First Name	Last Name	MI	Preferred name:
			Gender: ☐ Male ☐ Female ☐ Other
Date of Birth:	SSN:		Home Phone: ( )
Street Address (including apt # if needed):			Cell Phone: ( )
City, State, Zip Code:			Email:
Name of your intended recipient:			Relationship:
Preferred day/time during business hours for a 15-20 minute phone call:			

Primary Care Provider (PCP) Name:	PCP Phone #: ( )	PCP Fax #: ( )
PCP Mailing address: City, State, Zip Code:		
Height: Weight:	Current Nicotine Use (smoking, vaping, chewing, etc…) ☐ Yes ☐ No	Blood Type: □ A □ B □ O □ AB □ I don't know

Please indicate if you have any of the following (past or current)

- □ Abnormal Pap or mammogram
- □ Bladder or kidney infections
- □ Blood clots or stroke
- □ Cancer of any kind; Type:
  Date of diagnosis:
- □ Chronic infections
- □ Diabetes; Age of diagnosis:
- □ Heart disease
- □ High blood pressure; Age of diagnosis:
- □ Kidney stones or disease
- □ Lung disease
- □ Mental health concerns to include depression, anxiety, panic attacks, or any other diagnosed mental illness

Current Medications:

Please provide any additional information about your health:

Primary Insurance:	Subscriber #:	Group #:

The following documents must accompany the form, otherwise referral process may be delayed:

- □ UVMMC ROI
- □ Consent for Living Donor Evaluation

Please Fax to (802) 847-3619 or Mail to:
UVM Medical Center Transplant Program
1 South Prospect Street, Rehab 2
Burlington, VT 05401
Questions: Call us at (802) 847-4774