Providence
Sacred Heart Medical Center
Transplant Services

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Spokane WA 99204
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TRANSPLANT CANDIDATE REFERRAL FORM

In order to expedite your patient's referral process, we require the following information:

Referral Date:	Nephrologist/PCP:	
Patient Name:		
Address:		
City / State / Zip		
DOB:	**SEX**: ☐ M ☐ F	**SS#**:
Home Phone:		**Cell phone**:
Ethnic Group: ☐ Caucasian ☐ Black ☐ Native American ☐ Hispanic ☐ Asian ☐ Other		
Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Married - Spouse' Name:		**U.S. Citizen:** ☐ Y ☐ N
Employer:		**Occupation:**
Please check what applies: ☐ **FT** ☐ **PT** ☐ **Retired** ☐ **Disabled**		
Insurance Name: ***Send copy of Card***		**Insurance ID#**
Subscriber:		**Subscriber Employer**:
Medicare#:		**Medicaid #**:
Cause of Renal Failure:		
Chronic Dialysis: ☐ **No** ☐ **Yes, Type (Circle) HD / PD / Cycler**		**Date of First Dialysis (send copy of HCFA 2728)**
Dialysis Unit:		Scheduled Days/Time:
Previous Transplant: ☐ No ☐ Yes Type: ☐ Living Donor ☐ Deceased Donor		List Date/Place of Previous Transplant/s:

Please include the following medical records with your referral:

- ☐ **Copy of insurance card(s)** front & back
- ☐ **History & Physical**
- ☐ **Progress Notes-** (MD office and/or dialysis)
- ☐ **Medical/Surgical Consultations**
- ☐ **Copy of HCFA 2728**
- ☐ **Compliance Report** (missed treatments)
- ☐ **Radiologic Exams-** CXR, Kidney US, CT, VCUG-any other radiology reports
- ☐ **Labs-** current results (including serologies)
- ☐ **Pathologies/kidney biopsies**
- ☐ **Social Worker Evaluations**
- ☐ **Cardiac testing-** EKG, stress test, echo, heart cath