Please send to:

Kidney Transplant Coordinator
4220 Harding Road • Nashville, TN 37205
P: (615) 222-6618 • **F:** (615) 222-6074
stwkidneyreferrals@ascension.org

RENAL TRANSPLANT REFERRAL FORM

Person completing form: ____ Date: ____________________

Please email or fax the completed form along with the following documents:

___ Demographics, Insurance cards
___ Medication list
___ History and physical
___ Medicare 2728 form *printed from CROWNWeb*

Optional:
___ Medical Imaging
___Lab Results
___ Psych/Social

Name:____
Address: ______________________________________
____

Phone:
H:____
C:____
W:____

Referring Physician: ____________________________
Phone:_______________________________________
Fax:____

Sex:________________Race:_________________
DOB: ________________ Age:_____________________
SS#____
Emergency Contact:_____________________________
____
Emergency Contact's Phone:______________________
Dialysis Center:_________________________________
Phone:_______________________________________
Fax:____
Cause of ESRD:____

Type of Dialysis: ___Hemodialysis ___Peritoneal ___Not yet on dialysis
Date dialysis started: _____________
Compliance: ___Excellent ___Good ___Fair ___Poor

Comments regarding compliance: ____
____
____

Does the patient have a living donor? __Yes __No__Possible

Body Mass Index (BMI):__________

Tobacco:___Ever ___Now How much? ______________________
Alcohol: ___Ever ___Now How much? ______________________
Drugs: ___Ever ___Now How much? ______________________

Employment status: ___ Working ____Not Working

Functional Status: ___Good ___Fair ___Poor Comments:_____________________________________