UCLA Health
Transplant Services
Kidney and Pancreas Transplant Programs

UCLA Kidney and Pancreas Transplant Program
Referral Form

Thank you for referring your patient!
To start the referral process, please fax the following documents to (310) 983-3620:
1) Referral Form, 2) Both sides of insurance card, 3) Insurance authorization and 4) 2728 Form, if on dialysis.
If you require additional assistance, please call (310) 825-6836.

Patient Information

Last Name: _____ First Name: _____ MI: _____ SSN: _____ Gender: M / F
DOB: ____/____/____ Address: _____ City: _____ State: ____ Zip: _____
Race / Ethnicity: _____ E-mail: _____
Home #: (_____)_____-_____ VM: Y / N | Work #: (_____)_____-_____ VM: Y / N | Cell / Other #: (_____)_____-_____
Emergency Contact #: (_____)_____-_____ Name: _____ Relationship: _____
Mother's Maiden Name: _____ Marital Status: _____
Citizenship Status: _____ Country Of Origin: _____

Primary Language:	Interpreter? Y / N	Special Needs? Y / N

Physician Information

Referring Physician: _____
Practice / Group Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (____)_____-_____ Fax: (____)_____-_____
E-mail: _____

Primary Care Physician: _____
Practice / Group Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (____)_____-_____ Fax: (_____)_____-_____
E-mail: _____

Insurance Information

Medicare #: _____ Medical #: _____ Health Plan: _____
HMO / PPO ID #: _____ Insurance Phone #: (_____)_____-_____ Group #: _____
Are Patient Insurance Premiums Being Paid Thru American Kidney Fund? Y / N
Insurance Subscriber's Name: _____ Relationship To Patient: _____
Subscriber's DOB: _____/_____/_____ Subscriber's SSN: _____ Kaiser #: _____
Kaiser Facility: _____ Case Manager: _____

Patient's General Clinical and Dialysis Information

Dialysis: Y / N | Dialysis Days: MWF / TTS / PD / Other: _____ Date Of First Dialysis: ____/_____/_____
Name Of Dialysis Center: _____
Address: _____City: _____ State: _____ Zip: _____
Phone: (_____)_____-_____ Fax: (_____)_____-_____ Dialysis Unit Social Worker: _____
Height: _____'_____" Weight: _____ lbs / kg | BMI: _____ Date: _____/_____/_____
Cause Of Chronic Kidney Disease: _____
Most Recent Hospitalization Date: _____/_____/_____ Location: _____

UCLA MR #:	Living Donor Y / N	Is Patient Able To Make Medical Decision? Y / N
History Of Previous Transplant? Y / N | If Yes, TX Date ____/____/_____ Which Organ?		
Is The Patient Currently Listed At Another TX Center? Y / N | Name Of TX Center:		
Has the Patient Been Denied For TX At UCLA Or Other TX Center? Y / N | If So, Reason(s):		
Ambulatory: Y / N | Reason:		Assisted Living Facility: Y / N