NEW PATIENT EVALUATION REGISTRATION SHEET

Kidney/Kidney-Pancreas/Kidney-other

UCLA Health
Transplant Services
Kidney and Pancreas Transplant Programs

DEMOGRAPHIC INFORMATION:	***DIALYSIS INFORMATION:***
Last Name:	Dialysis Unit:
First Name: MI:	Address:
Address:	City/State/Zip:
City/State/Zip:	MWF: TTHS: Shift:
DOB: SSN#	Dialysis Unit Social Worker:
Have you ever been seen at UCLA: Y / N Date:	Phone#: Fax#:
UCLA#:	***REFERRING PHYSICIAN:***
Gender: Male: Female:	Name:
Race/Ethnicity:	Address:
Home#: Voicemail Y / N	City/State/Zip:
Work#: Voicemail Y / N	Phone#: Fax#:
Misc# (Cell): Voicemail Y / N	***PRIMARY CARE PHYSICIAN:***
Emergency Contact #: Name: Relation:	Name:
Mother's Maiden Name:	Address:
Citizenship Status/Country of Origin:	City/State/Zip:
Marital Status:	Phone#: Fax#:
INSURANCE INFORMATION:	***COMMENTS:***
Medicare#: Medical#:	Primary Language:
HMO / PPO ID#:	Do You Have A Donor: Y / N
Group #:	Relationship To Donor:
Are pt. insurance premiums being paid thru American Kidney Fund? Y / N	**Is patient able to make medical decisions:** Y / N
Insurance subscriber's name:	**If no – Why?**
Relationship to patient:	**If no – Does patient have Durable Power of Attorney? Y / N *(patient needs to bring in DOA at apt.)***
Subscriber's DOB#:	
Subscriber's SSN#:	***APPOINTMENT INFORMATION:***
Kaiser#: Kaiser Facility:	*Orientation: / / @ 10:00 am*
Case Manager:	**New Referrals Contact**: **Fax all referrals to: (310) 983-3620** Felicia Magallanes (Last name A-F) Ph: 310-267- 6932 Rosa Garcia (Last name G-M) Ph: 310-267-6937 Norma Munoz (Last name N-Z)Ph: 310-267-6933
Have you been evaluated at another Transplant Center: Y / N **If yes – name of Center:_____** **Are you listed at another transplant center: Y / N**	

Referred By: Dialysis Unit _____; Insurance_____; MD_____; Self_____ *Received By:_____/Date:_____*

Height: _____ Weight: _____ BMI: _____ *V.M:_____ Contacted Pt:_____ Completed Intake:_____*

Assisted Living Facility: Y / N Ambulatory: Y / N Reason: _____