Memorial Health

Request for Transplant Consultation
Fax completed form to 217–788–4606.

PATIENT REFERRAL INFORMATION

Date of referral ________________________

Name ________________________ DOB ________________________

Address ________________________ City/State/ZIP ________________________

Phone ________________________ SS# ________________________

Who is referring patient to Memorial Transplant Care? ________________________

Name/title of person completing this form ________________________

Nephrologist ________________________ Phone ________________________

Patient on dialysis? ☐ Yes ☐ No   Dialysis type ________________________

Dialysis unit ☐ DaVita ☐ Fresenius   Unit location ________________________

☐ Other ________________________   Dialysis schedule ☐ M-W-F ☐ T-T-S ☐ Other

Dialysis unit phone ________________________ Fax ________________________

Is patient listed or being worked up at any other transplant facility? ☐ Yes ☐ No

If yes, name of facility ________________________

Does the patient use oxygen? ☐ Yes ☐ No   PCP ________________________

Is the patient diabetic? ☐ Yes ☐ No

Does the patient have calciphylaxis? ☐ Yes ☐ No

Patient Demographics

Height____________ Weight____________   Does the patient use nicotine? ☐ Yes ☐ No

Insurance Information

Primary________________________ ID#________________________

Secondary________________________ ID#________________________

Please send the following information with referral:

- Copies of insurance cards (front and back)
- Radiology within the past 12 months
- History and physical (including surgical history)
- Last three months of dialysis logs
- Cardiac testing
- Medication list
- Form 2728
- **Current** lab work

For questions, contact Memorial Transplant Care at 217–788–3441.