Kidney Transplant Program
REFERRAL FORM
Phone: (832) 355-4100
Fax: (713) 383-1589

Referral Date:
Cleared Date:

PATIENT INFORMATION

Last Name:	First:		Middle:	Social Security:	
*DOB:	Sex: ☐M ☐F	Language:	Ethnicity:	*Weight:	*Height:
Street Address:			City:	ST:	ZIP:
Home Phone :	Cell Phone No:	Email Address:	Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed		
Alternate Contact and Phone No.:			Spouse's Name:		

DIALYSIS CENTER

Are you on dialysis? ☐ No ☐ Yes	Type: ☐ HD ☐ PD	Date Started:	Days:	Shift:
Dialysis Name (Please be specific):		Phone No.:	Fax No.:	

Are you listed at or being seen by another transplant center? ☐Yes ☐ No	If so, where were you evaluated? When were you listed?

BASIC MEDICAL

What is the cause of your kidney disease?	☐ Unknown
Do you have high blood pressure?	☐ No ☐ Yes ☐ Unknown
Do you have high cholesterol?	☐ No ☐ Yes ☐ Unknown
Are you HIV positive?	☐ No ☐ Yes ☐ Unknown
Do you have hepatitis?	☐ No ☐ Yes ☐ Unknown
Had any blood transfusions?	☐ No ☐ Yes ☐ Unknown
*Had a stroke or suspected stroke?	☐ No ☐ Yes ☐ Unknown
Had any transplants?	☐ No ☐ Yes
Been diagnosed with cancer?	☐ No ☐ Yes Type:
Are you a diabetic?	☐ No ☐ Yes
If yes, are you on insulin?	☐ No ☐ Yes
*Are you wheelchair bound	☐ No ☐ Yes
*Do you require any assistance walking?	☐ No ☐ Yes
*Do you live in a nursing home?	☐ No ☐ Yes
*Have you ever had a Coronary Heart Bypass Procedure?	☐ No ☐ Yes ☐ Unknown
Had any of the listed surgeries? ☐ Heart ☐ Hernia ☐ Gallbladder ☐ Parathyroid ☐ Amputation ☐ Hysterectomy ☐ Other:	
Medication Allergies: ☐No ☐Yes	If yes, which ones?

Revised: 06/30/2014

PHYSICIAN INFORMATION

Which doctor recommended you to pursue a transplant?			
Address:		Phone No.:	Fax No.:
Do you have a primary care physician? ☐ No ☐ Yes		Name:	Phone No.:
Do you see any other physicians? ☐ No ☐ Yes - If yes, list their names, specialties, phone and fax numbers below:			
Name:	Specialty:	Phone No.:	Fax No.:
Name:	Specialty:	Phone No.:	Fax No.:
Name:	Specialty:	Phone No.:	Fax No.:

INSURANCE INFORMATION

Primary:	HMO: ☐ No ☐ Yes
ID No.:	Group No.:
Benefits No.:	Name of insured:
Secondary:	HMO: ☐ No ☐ Yes
ID No.:	Group No.:
Benefits No.:	Name of insured:

NOTES:

*Please see Kidney Evaluation Initial Screening

Kidney Evaluation Initial Screening

1. **BMI requirements using Height? Weight?**
   a. If BMI> 45, unable to evaluate at this time and refer patient to a dietician for education.
   b. If BMI >40, but <45, schedule patient to see surgeon for transplant candidacy
   c. If BMI< 40, okay to proceed with insurance verification and scheduling.

		Weight in pounds		
	Height	BMI=35	BMI >40	BMI >45
58	4'10"	167.5	191.4	215.3
59	4'11"	173.3	198.1	222.8
60	5'0"	179.2	204.8	230.4
61	5'1"	185.3	211.7	238.2
62	5'2"	191.4	218.7	246.1
63	5'3"	197.6	225.8	254.1
64	5'4"	203.9	233.1	262.2
65	5'5"	210.3	240.4	270.4
66	5'6"	216.9	247.9	278.8
67	5'7"	223.5	255.4	287.3
68	5'8"	230.2	263.1	296.0
69	5'9"	237.0	270.9	304.8
70	5'10"	244.0	278.8	313.7
71	5'11"	251.0	286.8	322.7
72	6'0"	258.1	295.0	331.8
73	6'1"	265.3	303.2	341.1
74	6'2"	272.6	311.6	350.5
75	6'3"	280.0	320.1	360.1
76	6'4"	287.6	328.6	369.7

2. **Age limitations**
   a. >or equal to 70, schedule patient to see nephrologist to determine candidacy
   b. <70, okay for scheduling day 1 evaluation
3. **Can the patient ambulate? Do they require any assistance walking?**
   a. If patient is wheelchair bound, schedule patient for nephrologist to determine candidacy
4. **Diagnosed with any Cancer?**
   a. If the patient has been diagnosed with cancer in the last 3 years, schedule patient with a nephrologist to determine candidacy.
5. **Do you live in a Nursing home?**
   a. If the patient resides in a nursing home, please schedule with nephrologist to determine candidacy.
6. **Have you ever been diagnosed with a stroke?**
   a. If yes, please schedule with a nephrologist prior to evaluation to determine candidacy
7. **Have you ever had a Coronary Heart Bypass Procedure?**
   a. If yes, please schedule with a nephrologist prior to evaluation to determine candidacy

***Please send a referral message to the transplant coordinators, indicating why the patient is being referred to a nephrologist prior to eval for follow-up. ***