

Med Rec No: ___/___/___
ABO: _____

Patient Type: **ACHD** **ECP**
 Pre-TXP: Heart, Kidney, Kidney/Pancreas
 Post-TXP: Heart, Kidney, Kidney/Pancreas &
Name of Center Transplanted at:

REFERRAL INFORMATION:				
Referral Date: ___/___/___	Referral Source: _____	[] Inpatient [] Outpatient		
Previous TXP Date: ___/___/___	Place of Transplant: _____	Lost Graft Date: ___/___/___		
TXP Wait List: [] Yes [] No	Place of Listing: _____	Date of Listing: ___/___/___		
PATIENT INFORMATION: Has patient been seen at any other Sutter Facility? [] Yes [] No				
				[] Female
<i>Patient Last Name</i>	<i>First</i>	<i>Middle Name</i>	<i>Maiden Name</i>	[] Male
<i>Address</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>County</i>
<i>Home Phone</i>	<i>Work Phone</i>	<i>Pager</i>	<i>Other</i>	
<i>Age</i>	<i>Birth Date</i>	<i>Social Security No.</i>	<i>Religion</i>	<i>Marital Status</i>
<i>Patient Employer</i>	<i>Occupation</i>	<i>Disability Date</i>		
<i>Spouse's Name/Significant Other</i>	<i>Birth Date</i>	<i>Social Security No.</i>		
<i>Spouse's Employer</i>	<i>Work Phone</i>	<i>Occupation</i>		
<i>Emergency Contact</i>	<i>Relationship</i>	<i>Phone</i>		
<i>Primary Language</i>	<i>Name of Interpreter</i>	<i>Relationship of Interpreter to Patient</i>	<i>Phone</i>	
PHYSICIAN INFORMATION:				
<i>Primary Care MD</i>	<i>Address</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>
<i>Phone</i>	<i>Fax</i>			
<i>Specialist MD</i>	<i>Address</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>
<i>Phone</i>	<i>Fax</i>			
<i>Dialysis Unit/Other/Transplant Clinic</i>	<i>Address</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>
<i>Phone</i>	<i>Fax</i>	<i>Initial Dialysis Date</i>	<i>CAPD/Hemo</i>	<i>Schedule</i>

Patient Name: _____

PATIENT INSURANCE INFORMATION?:

Name of Insurance Company	Phone	Policy #	Group #
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If Group Plan, State Employer

SPOUSE/OTHER INSURANCE INFORMATION:

Name of Insurance Company	Phone	Policy #	Group #
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If Group Plan, State Employer

ETHNICITY/RACE:

<input type="checkbox"/> African American (Black)	<input type="checkbox"/> Chinese	<input type="checkbox"/> Filipino (Pacific)	<input type="checkbox"/> Thai	<input type="checkbox"/> Hispanic: Mexican
<input type="checkbox"/> Native American (Alaskan)	<input type="checkbox"/> Japanese	<input type="checkbox"/> Laotian	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Hispanic: Other
<input type="checkbox"/> Caucasian (White)	<input type="checkbox"/> Cambodian	<input type="checkbox"/> Indian: Sub Continent	<input type="checkbox"/> Mideast: Arabian	<input type="checkbox"/> Other:
<input type="checkbox"/> U.S. Citizen	<input type="checkbox"/> Resident Alien	<input type="checkbox"/> Non-Resident Alien,	Country: _____	

CLINICAL ACTIVITY:*Medical Records Requested: Yes No Requested From: _____ Fax Mail

*(Recent office notes, hospital summaries, labs, EKG, echo, CXR, PFT's, treadmill, heart cath, holter)

Referral Outcome Information:

Date Case Closed: _____	<input type="checkbox"/> Consult Scheduled	<input type="checkbox"/> Closed: Insurance*	<input type="checkbox"/> Expired
_____ / _____ / _____	<input type="checkbox"/> Incomplete*	<input type="checkbox"/> Closed: Other*	<input type="checkbox"/> Withdrew

* Explanation: _____

Rejected: _____ / _____ / _____ UNOS List: _____ / _____ / _____ Listing Wt: _____ kg Listing Ht: _____ cm

TXP Date: _____ / _____ / _____ Type: _____

Physician notified of Transplant: _____ Dialysis notified of Transplant: _____