Kidney Transplant Services Recipient Referral

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Please read before completing this form

This from is intended for referrals of potential transplant recipients.

You may complete this form, to the best of your ability, and mail or fax to Presbyterian Transplant Services.

Please use this as the cover sheet when sending completed form.

Address: Presbyterian Transplant Services.
201 Cedar Ave SE, Suite 820
Albuquerque, NM 87106
Fax number: (505)563-6137

If you would like to speak with a Transplant team member before completing this form, or if you need assistance completing it, please call **(505) 841-1434**. Once we receive the completed form, a Transplant team member will contact the patient to complete the referral process and schedule Transplant Orientation Class.

RECIPIENT INTAKE FORM

☐ Kidney
☐ Kidney/Pancreas
☐ Pancreas Only

DEMOGRAPHICS

Referral Date:		Referral Type: ☐ Self ☐ Family ☐ MD ☐ Dialysis	
Patient Name:			
DOB:		SSN:	
Sex:	**Height:**	**Weight:**	**BMI:**
Mailing Address:			
City:	State:	Zip Code:	
Home:	Work:	Cell:	
Primary Language:		Email:	
Emergency contact:		Phone:	
Emergency contact:		Phone:	
Do we have permission to leave messages on: ☐ Home ☐ Cell ☐ with Others			
Work Status:			
Marital Status:			
Ethnicity/Race:			

DIALYSIS INFORMATION

Type of Dialysis: ☐ Pre-Dialysis ☐ Hemodialysis ☐ Peritoneal Dialysis	
Dialysis Start Date:	
Name of Dialysis Clinic:	
Fistula location on Body:	
Days: ☐ M, W, F ☐ T, TH, SAT	Time you Start:
Cause of Kidney Disease:	
What is your GFR? (Glomerular Filtration Rate):	

HOSPITALS & CLINICS

Nephrologist (Kidney Doctor):	Phone:
Primary Doctor:	Phone:
Cardiologist:	Phone:
OB/GYN (Women):	Phone:
Other Clinics/Hospitals	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Orientation: ___________________________

RECIPIENT INTAKE FORM

INSURANCE/BILLING INFORMATION:

Primary Insurance:	Secondary Insurance:
Member/Policy ID#:	Member/Policy ID#:
Group #	Group #
Customer service Phone#:	Customer service Phone#:
Insurance verified ☐ Date verified: ___________________	

RECIPIENT MEDICAL QUESTIONNAIRE

Are you still currently Urinating: ☐ Yes ☐ No	How many times a day?	
Have you had a Transplant Before: ☐ Yes ☐ No Date of Transplant:	Where were you Transplanted? What organ?	Do you now or have you taken immunosuppression? ☐ Yes ☐ No If yes: What medication(s): For how long?
Please list any known Medical Allergies (Food, Animals, Medications, etc.):		
Have you ever had a Blood Transfusion: ☐ Yes ☐ No	If Yes When? How many?	
Do you have Diabetes: ☐ Yes ☐ No	Age or year you were Diagnosed:	
Do you have Hypertension: ☐ Yes ☐ No	Age or year you were Diagnosed:	
Have you ever had an Echocardiogram: ☐ Yes ☐ No	Last One Done:	
Have you ever had a Stress Test: ☐ Yes ☐ No	Last One Done:	
Have you ever had a Heart Catheterization: ☐ Yes ☐ No	Date:	
Have you ever had Tuberculosis: ☐ Yes ☐ No	When:	
Have you ever had Hepatitis: ☐ A ☐ B or ☐ C ☐ Never	When:	
Have you had a Hepatitis B vaccine: ☐ Yes ☐ No	When:	
Do you have any history of: ☐ ☐ Smoking (cigarettes) ☐ Vaping ☐ Alcohol Abuse ☐ Marijuana ☐ I.V. Drug use ☐ Edibles Other drug use None	Comments What did you use? For how many years Quit date/year	

RECIPIENT INTAKE FORM

Are you currently using: ☐ A Wheelchair ☐ A Walker ☐ Prosthetics ☐ None of these	If yes, how frequently and for how long?

WOMEN

Your last OB / GYN Visit:	Last Pap Smear:	Last Mammogram:

How many Pregnancies?	How many child births?
Have you ever had a Colonoscopy: ☐ Yes ☐ No	When was your last one?

MEN

Do you have any Prostate Problems: ☐ Yes ☐ No	What problems do you have (Enlarged Prostate)?
Have you had a Prostate-Specific Antigen (PSA) Testing: ☐ Yes ☐ No	When was the last test done?
Have you ever had a Colonoscopy? ☐ Yes ☐ No	When was your last one?

OTHER INFORMATION

When was your last Dental Visit:	Do you have any Dentures or Partials? ☐ Dentures ☐ Partials ☐ Top ☐ Bottom ☐ Both

Do you have any Potential Donors: ☐ Yes ☐ No	Who might they be:
Have you had Cancer? ☐ Yes ☐ No Date________________	If so, Please Explain what type?

Past Surgical History	
Surgery	**Date/Location**

Additional comments or Medical History not covered