UCDAVIS HEALTH | Transplant Center

Phone: 916-734-2111 Fax: 916-734-5194 Living Donor Team Phone: 916-734-2307
https://health.ucdavis.edu/transplant https://health.ucdavis.edu/transplant/livingkidneydonation

KIDNEY TRANSPLANT REFERRAL FORM						
Referral Date			Source ◯ Dialysis Unit ◯ Physician's Office			
Patient Demographics						
Last Name			First Name			
Address						
City	State		Zip Code			
Home Phone	Work Phone		Mobile Phone			
DOB	Age		Sex Assigned At Birth			
Email						
Potential Living Donor ◯ Yes ◯ No						
Insurance						
Insurance Provider			Benefits Phone Number			
Subscriber Name			Subscriber ID			
Insurance Provider			Benefits Phone Number			
Subscriber Name			Subscriber ID			
Special Considerations						
Preferred Language			Interpreter Required ◯ Yes ◯ No			
Communication Barriers (ex. Hearing Loss, Blindness)						
Medical History						
Height	Weight		BMI			
Dialysis Information						
◯ Not On Dialysis	◯ In-Center HD	◯ Home HD	◯ CAPD	◯ CCPD	Days	Time
Dialysis Center					Facility Start Date	
Address					Dialysis Start Date	
City	State		Zip Code			
Phone	Fax					
Provider Information						
Nephrologist			Address			
Phone	Fax		Email			
Renal Case Manager/Social Worker						
Phone	Fax		Email			
Primary Care Physician			Address			
Phone	Fax		Email			
Required Additional Information						
Yes ◯ No ◯ Age equal to or greater than 75 years						
Yes ◯ No ◯ BMI equal to or greater than 40						
Yes ◯ No ◯ Active cigarette smoking						
Yes ◯ No ◯ Physical deconditioning requiring the use of a wheelchair, walker or scooter						
Yes ◯ No ◯ Advanced lung disease requiring home oxygen use						
Yes ◯ No ◯ Non-compliance with dialysis within the last 6 months						
Yes ◯ No ◯ Non-healing foot ulcer						

Clear Form