Attention:_____ Date:_____

Referring MD_____ Phone_____ Fax_____

Address_____

NPI # _____ (necessary to schedule appointments)

Referral to Solid Organ Transplant at Children's Hospital

Please provide the following information so that we can schedule your patient for a renal transplant evaluation. Please let them know that they can expect to hear from us about 1-2 weeks after all of the requested information is received. Thank you for your referral to our center.

Patient Information:

Name_____ Date of Birth_____ Age _____

Address_____

Parent or Guardian name _____

Home Phone_____ Work Phone_____ SSN_____

Insurance Name_____ Phone#_____ ID#_____

Group Number_____ Insured's Name_____ Relationship _____

Primary Diagnosis: End Stage Renal Disease secondary to_____

Pertinent Medical History_____

_____

_____

Past Surgeries_____

_____

Current Medications_____

_____

Pt's height _____ Pt's weight _____ Dialysis start date_____ Type of dialysis _____

GFR _____ Current dialysis unit and contact person_____

Please return this completed form with copies of:

- **Recent History & Physical or letter from MD with clinical summary**
- **Recent lab data and clinic notes**
- **Recent hospitalization records**
- **Renal biopsy, radiology, renal ultrasound, VCUG, blood type, OP notes, discharge summaries, immunization records, TB skin test, dental checkup clinic note**

Mailing address:
Solid Organ Transplant
The Children's Hospital
1600 7th Avenue South
ACC Suite 404
Birmingham, AL 35233

Phone: 205-939-6631
Fax: 205-558-2319

ATTENTION: TRANSPLANT COORDINATOR