**HALIFAX HEALTH**

**CENTER FOR TRANSPLANT SERVICES**
311 N. Clyde Morris Blvd., Suite 360, Daytona Beach, FL 32114
(386) 425−4650 • Fax (386) 425−7510

Patient Name
Adm. Date Dr.
Date of Birth Age Sex
MR # Visit #

# CANDIDATE REFERRAL FORM

Referral Date:_____ Referral Source: ❑ MD ❑ Dialysis Center ❑ Self ❑ Other: _____

Patient Name:_____ Maiden: _____ Date of Birth: _____

Social Security Number: _____ Sex: ❑ Male ❑ Female Marital Status: _____

Address:_____ Apt:_____ City, State, Zip:_____

Home Phone: _____ Work Phone: _____

Cell Phone:_____ Primary Care MD: _____ Phone:_____

Nephrologist:_____ Dialysis Center:_____

Nephrologist Phone #:_____ Dialysis Phone #: _____

Cause of Renal Disease :_____ (Medicare 2728 form required if on dialysis)

Initiation of Dialysis:_____ Diabetic: ❑ Yes ❑ No Onset Age: _____

Please circle: Peritoneal / Hemodialysis Schedule: SU M TU W TH F SA ❑ AM ❑ PM

Height _____ (cm) Dry Weight: _____ (kg)

Primary Insurance:_____ ID Number:_____

Secondary Insurance:_____ ID Number:_____

Pharmacy Benefits:_____ ID Number:_____

Are you receiving assistance paying for your premiums? ❑ Yes ❑ No Transplant Organ: ❑ Kidney

Prior Transplants? ❑ Yes ❑ No Organ:_____ Year:_____ How Many:_____

Organ:_____ Year: _____How Many:_____

**Medical / Social Concerns:** _____

_____

Transplant Liaison Contact Name and #: _____

**Thank you for your interest in kidney transplant at Halifax Health. Please send the required documents by mail or fax via our secured fax. The patient will be contacted regarding scheduling of an appointment after referral is received. We look forward to meeting your patient and the opportunity to work with you.**

**Required Records Requested for Referral Entry:**
❑ Copy of insurance cards, front and back or write policy and claims number on separate sheet of paper.
❑ Current history and physical within the past 12 months, referral CANNOT be processed without current H&P
❑ Recent labs, PSA if age 50 and older
❑ Psychosocial evaluation/social work assessment
❑ Medicare 2728 form if on dialysis
❑ Vaccination reports
❑ Dialysis rounding reports

**Testing required for evaluation, please include current reports, if available:**
❑ Cardiac stress test, if over age 35, and cardiac echo on all candidates
❑ Routine cancer screens: Pap smear, mammogram, colonoscopy (as recommended by the ACS).
These are not part of the transplant evaluation and are required for acceptance.
❑ Provide any pertinent records based on medical history, example: Rheumatology, surgical, endocrine, and others

**If reports available from within the past 6 months:**
❑ Chest X−ray
❑ EKG

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