PennState Health
Milton S. Hershey Medical Center

Solid Organ Transplant Program
Abdominal Transplant

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800-525-5395
717-531-3717 Fax

Kidney Transplant Referral Form

Patient Name: ______________________________

DOB: __________________

Height: _________________

Current Weight: _________________

BMI: _________

Cause of Organ Failure:

____

Nephrologist/Referring Provider:

Name: __________________________

Phone: __________________________

Fax: ____________________________

Primary Care Provider:

Name: __________________________

Phone: __________________________

Fax: ____________________________

Dialysis Center (if applicable):

Name: __________________________

Phone: __________________________

Fax: ____________________________

Name of Dialysis Contact: ____________________

Type of Dialysis: ___________________________

Days: _______________ Shift: _______________

Special Considerations:

Has this patient used 4L O2 for more than 6 months recently? **Yes or No**

Has this patient had a myocardial infarction within that last 6 months? **Yes or No**

Does this patient have a history of Cancer? If yes, please answer questions below: **Yes or No**

Specify Type: __________________

Date diagnosed: _________________

Type of Treatment: ____________________

Is this patient's primary language English? **Yes or No**

Would an interpreter be helpful? **Yes or No**

Specify language: _______________

Is this patient currently list or in the txp eval. Process? **Yes or No**

Center: _________________________

Phone: __________________________

Required Documents:

- **Demographic sheet**
- **Front and back of all insurance cards**
- **Complete Medical H&P**
- **Current Medications**
- **CMS 2728 Form - If on dialysis**

Any additional information you feel is pertinent:

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Thank you for this referral. We will fax you notification of transplant evaluation date and time.

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