EMORY
TRANSPLANT CENTER

Address: Emory Transplant Clinic Attn: Post Transfer Care Coordinator 1365 Clifton Rd., NE Atlanta, Georgia 30322
Phone: 855-EMORY-TX (366-7989) **Fax:** 404-712-0604

POST KIDNEY TRANSPLANT REFERRAL FORM

REFERRING PROVIDER & TRANSPLANT CENTER

Referral Date:			
Referring Physician:			
Referring Address:			
Phone #:		Fax #:	
Transplant Center:			
Address:			
Phone #:		Fax #:	

PATIENT DEMOGRAPHICS

Patient's Name:					
	(First)	(M.I.)		(Last)	
Date of Birth:		Social Security #:			
Street Address:					
City		State:		Zip Code:	
Home Phone #:		Cell Phone #:			
Other Phone #:		Email Address:			
Preferred Language:		Race:			
Employer:		Occupation:			

RENAL TRANSPLANT INFORMATION

Transplant Date:		Baseline Creatinine:	

EMERGENCY CONTACT INFORMATION

Emergency Contact:		Relationship to Patient:	
Phone #:		Secondary Phone #:	

PRIMARY HEALTH INSURANCE INFORMATION

Insurance Company:			
Policy #:		Group #:	
Insurance Subscriber:		Patient Relationship to Subscriber:	

SECONDARY HEALTH INSURANCE INFORMATION

Insurance Company:			
Policy #:		Group #:	
Insurance Subscriber:		Patient Relationship to Subscriber:	

TERTIARY HEALTH INSURANCE INFORMATION

Insurance Company:			
Policy #:		Group #:	
Insurance Subscriber:		Patient Relationship to Subscriber:	

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REQUIRED DOCUMENTATION

I have included the following Medical Records for the patient in order to ensure a smooth transition.

☐Three (3) most recent Transplant Office Notes
☐Three (3) most recent Transplant Lab Results
☐Most recent Medication List
☐Transplant Operative Note
☐Transplant Related Biopsy Report(s)
☐Transplant Related Imaging
☐Copy of Patient's Insurance Card(s)

This form has been completed by:		Title:	
Organization:			
Phone #:		Fax:	

To be completed by Emory Transplant Center

Received Date: _____ Received By: _____ N M B I O L R
☐O-Office Notes ☐M-Medication List ☐B-Biopsy Report(s) ☐I-Insurance Card(s) ☐O-Operative Note ☐L-Lab Results ☐R – Imaging