Saint Thomas
WEST HOSPITAL

Please send to:

Kidney Transplant Coordinator
4220 Harding Road • Nashville, TN 37205
P: (615) 222-6618 • **F:** (615) 222-6074

RENAL TRANSPLANT REFERRAL FORM

Name:_____
Address: _____
_____

Phone:
H:_____
C:_____
W:_____

Referring Physician: _____
Phone:_____
Fax:_____

Sex:_____Race:_____
DOB: _____ Age:_____
SS#_____
Emergency Contact:_____
_____
Emergency Contact's Phone:_____
Dialysis Center:_____
Phone:_____
Fax:_____

Cause of End Stage Renal Disease:_____
Type of Dialysis: ___Hemodialysis ___Peritoneal ___Not yet on dialysis
Date dialysis started: _____
Compliance: ___Excellent ___Good ___Fair ___Poor
Comments regarding compliance: _____
_____
_____

Heart Disease: ___Yes ___No Diabetes: ___Yes ___ No Body Mass Index (BMI):_____

Tobacco: ___Ever ___Now How much? _____
Alcohol: ___Ever ___Now How much? _____
Drugs: ___Ever ___Now How much? _____

Employment status:
___Working full time
___Working part time by choice
___Working part time due to disease
___Not working by choice
___Not working due to disease
___Not working unable to find employment
___Retired
___Disabled, Reason for disability_____

Person completing form: _____ Date: _____

Please fax the completed form to 615.222.6074 along with the following documents:

___ Demographics, Insurance cards
___ Medication list
___ History and physical
___ Discharge summaries
___ Medical Imaging
___ Psych/Social
___ Vaccinations
___ Medicare 2728 form
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