Kidney/Pancreas Referral Form

FAX TO: 734-232-1930

Type of transplant requested: Kidney______ Kidney/Pancreas_______ Pancreas Only_______

Patient Name: ____

Address:______________________________ **City:**______________ **State:**______ **Zip:**____________

Phone:___________________________________ **Date of Birth:**__________________________________

Male: ____ **Female:**_____ **US Citizen? YES NO Social Security#** ______________________________

Preferred language if not English____

Nephrologist: ______________________________ **Phone:**____________________

Primary Care Physician: ________________________ **Phone:**____________________

Diagnosis: ____________________ **Patient on Dialysis: YES NO GFR if not on dialysis** __________

If YES name of facility:______________________________________ **Phone:**_____________________

Start Date: ______________________________ **Type of Dialysis:** ______________________________

Previous Transplants: YES NO

If YES, which organ: ____________ **Facility:**_______________________ **Date of Transplant:**________

Who is sending referral?

Nephrology office_____ **Dialysis Center**_____ **PCP**_____ **Self-referral** _____

Name of person submitting request: _________________________________ **Phone:** ______________

*****So that we can process your request as quickly and thoroughly as possible, please complete this form and fax along with the below records*****

- ☐ 2728
- ☐ Dialysis adherence report
- ☐ Most Recent Office Note
- ☐ Most Recent Labs
- ☐ Most Recent Echo/Stress/CT (if available)

****Insurance information must be filled out below, even if card images are included. For all Medicare advantage plans, we must have the original Medicare (MBI) number.****

Primary insurance: _________________________________ **Insurance Phone#**__________________

Policy Holder:_________________________________ **Employer:**___________________________

Policy #____ **Group #**_____________________________

Secondary insurance:____________________________**Insurance Phone#**____________________

Policy Holder:_________________________________ **Employer:**____________________________

Policy #________________________________ **Group #**_______________________________

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

TRANSPLANT CENTER

Treatment Adherence Form

This form will be used to provide documentation regarding a patient's adherence to their treatment plan. This form will be used for both the initial kidney transplant evaluation and also yearly pre-kidney transplant visits. Thank you!

Patient Name and DOB: ____

For HD Patients:

- Attends/performs dialysis treatments on scheduled days/times Yes No
- How many missed (unexcused) treatments did the patient have in the past 6 months? _________
- How many times did the patient shorten their dialysis run time in the past 6 months? __________

For PD patients:

- Attends scheduled clinic visits Yes No
- Performs PD as prescribed Yes No

For both PD and HD patients:

- Takes all prescribed medications Yes No Needs Improvement
- Has a good working relationship with dialysis staff Yes No Needs Improvement
- Has adequate social support Yes No Needs Improvement
- Has adequate coping skills Yes No Needs Improvement
- History of frequent hospitalizations due to non-adherence Yes No

Please list any other concerns or barriers that prevent the patient from actively participating in his/her care.

____

____

________________________________ ________________
Dialysis Center Representative/Credentials Date

Please fax completed form to 734-232-1930 or email to txp-triage-all@med.umich.edu.

1500 E. Medical Center Drive, SPC 5334
Floor 1 Taubman Center, Reception G
Ann Arbor, MI 48109-5334
1-800-333-9013