Transplant Alliance

Evaluation Consultation/Referral Request Form
Kidney Transplant Program
One Medical Center Drive, Box 8301, Morgantown, WV 26506
Phone: (304) 974-3004 Fax: (304) 598-4899

Date: ____

Patient Name: ____

D.O.B: ____

Address: ____

____

Phone Number(s):____

Name of Insurance: ____
(Please attach a copy of the front and back of medical insurance card with this referral)

Dialysis Unit: ____

Dialysis Unit Phone Number: ____

Type of Dialysis: _____ HD _____ Home HD _____PD

Dialysis Schedule: ______M-W-F (AM or PM) ______ T-TH-S (AM or PM)

Dialysis Start Date/2728 Completed: ________________ **(please fax copy with referral)**

Reason for Renal Failure:____

Please fax this referral form and a copy of the patient's medical records, including most recent H&P, discharge summary, laboratory results, chest x-ray, EKG, cardiac studies, kidney biopsy, recent pap smear, mammogram, and immunization records to WVU Medicine Transplant Alliance at (304) 598-4899. Once the patient is scheduled for Teaching and Evaluation appointments, a confirmation letter will be sent to the patient, nephrologist, and dialysis unit. Thank you.