Atrium Health Transplant Center,
a facility of Carolinas Medical Center
PO Box 32861, Charlotte, NC 28232
Phone: 704-355-3855; 704-355-6649
Fax: 704-446-4876; 704-446-4875

Atrium Health

Referral Date: _____
☐ Kidney ☐ Kidney-Pancreas

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY TO EXPEDITE EVALUATION

Referring Nephrologist: _____

Dialysis Unit: _____ Contact Person: _____
or
Nephrologist office if pre-dialysis: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

PATIENT Legal Name: _____ _____ _____ DOB: _____
Last *First* *MI*

SS#: _____ Gender: ☐M ☐F Marital Status: ☐M ☐S ☐D ☐W Race: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Language: _____ Interpreter: ☐Yes ☐No US Citizen: ☐Yes ☐No

Emergency Contact: _____ Relationship: _____ Phone: _____

For patient's protection and in accordance with the HIPAA Privacy Act – Please check the following:

☐ Yes ☐ No I (patient) give permission for Kidney Transplant Dept. at Atrium Health to leave a detailed message on my voice mail.

☐ Yes ☐ No I (patient) give permission to discuss my medical condition with my emergency contact listed above.

Patient Signature: _____ Date: _____

INSURANCE: ☐ Medicare ☐ Medicaid ☐ Other: _____

MEDICAL INFORMATION Cause of Renal Disease: _____ Ht: _____ Wt: _____

Previous Transplant: ☐Yes When/Where: _____ ☐No Potential Living Donor: ☐Yes ☐No

DIALYSIS: Modality: ☐HEMO ☐HOME HEMO ☐CCPD ☐CAPD Days: ☐MWF ☐TThS Shift: ☐1 ☐2 ☐3 ☐PRE-DIALYSIS

Compliance: Misses Treatments a Month: _____ Early Signoffs a Month: _____ Misses Medications: ☐Yes ☐No

Allergies: _____ Recent Hospitalization: When/Where: _____

Diabetes: ☐Yes ☐No Tobacco Use: ☐Yes ☐No HIV: ☐Yes ID Physician: _____ ☐No

Special Needs: ☐Wheelchair ☐Prosthesis ☐Walker ☐Oxygen ☐Blind ☐Illiterate ☐Deaf

Comments: _____

REQUIRED DOCUMENTATION MUST BE INCLUDED WITH REFERRAL

☐ Insurance Cards: Legible front and back image
☐ History and Physical (within 1 year)
☐ Labs (within 3 months)
☐ Current List of Medications
☐ PPD Results
☐ Medicare Form 2728
☐ Nutritional Assessment
☐ Psych/Social Assessment