ASCREENCRIT

Referral for Post Renal / Pancreas Transplantation Follow-Up

Form Origination Date: 7/13
Version: 1
Version Date: 7/13

Patient Name ______________________
MRN ______________________
PATIENT IDENTIFICATION LABEL

Complete and return to:

MUSC Transplant Program
162 Ashley Avenue, MSC 586
Charleston, SC 29425

Fax: 843-876-2968
Email: KidneyTransplant@musc.edu

Date: ______________________

Patient Name: ______________________

Address: ______________________

Phone #: ______________________ Cell Phone #: ______________________

DOB: ______________________ Email Address: ______________________

Age: ________ Ht(cm): ________ Wt(kg): ________ Gender: ________ SS#: ________

Ethnicity:
- ☐ White
- ☐ American Indian/Alaska Native
- ☐ Hawaiian/Pacific Islander
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ Other: ______________________

Date of Transplant: ____________ Pre-Transplant Diagnosis: ______________________

Referring Physician Information

Referring Physician: ______________________

Address: ______________________

Phone #: ______________________ Fax #: ______________________

Comments or relevant clinical history: ______________________

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Compliance Information

Is patient compliant with appointments/medications? ☐ Yes ☐ No

If no, please comment: ______________________

____

How is patient paying for medications? ______________________

Referral should include:
- ☐ Completed referral form
- ☐ Copy of insurance cards (front & back)
- ☐ Medication list
- ☐ Clinical Documentation (H&P and/or Discharge Summary)
- ☐ Transplant flow chart (complications, rejections, treatment)

Referring Physician Signature: ______________________ Phone # ______________________

Referring Physician Name (Printed) ______________________