UCSF Medical Center | UCSF Benioff Children's Hospital

KIDNEY TRANSPLANT REFERRAL FORM

Thank you for referring us your patient. Please fax this form along with pertinent medical records and test results that support the consultation to **(415) 353-8708**. If you have questions, please call the clinic at: **(415) 353-1551.**

Date:	**From:**
No. of pages:	**Title:**
To UCSF practice: Pre-Kidney Transplant	**Phone:**
Fax: 415-353-8708	**Fax:**

PATIENT INFORMATION

Name of patient:

DOB: Interpreter needed: ❑ Yes ❑ No Language:

Home phone: ❑ Work or ❑ cell phone:

If child, name of parent:

Address:

City: Zip:

Insurance: **Include patient's insurance card (both sides) and HMO authorization if required**

CONSULTATION REQUEST INFORMATION

Diagnosis/ICD-9:

Name of UCSF MD (if known): Specialty:

Reason for consultation: Kidney Transplant Evaluation

By providing the information requested and signing below, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics, in association with this consultation. We look forward to collaborating with you on your patient's treatment plan.

REFERRING PHYSICIAN INFORMATION

Referring MD: Specialty:

Phone: Fax:

PCP name: Phone:

Signature: