Referring a Patient to: Kidney/Pancreas Transplantation Program at Mayo Clinic

Please fax this form to: (480) 342-0555
For questions, please call: (480) 342-1010
Thank you for referring your patient to Mayo Clinic.

Referring Physician Information

Referring Physician's Name First	Last		Date *(mm/dd/yyyy)*
Office Address			UPIN No./NPI No.
City	State	Zip	Telephone
Reply to Fax No.	Contact Person		

Patient Information

Patient Name First	Middle Initial	Last	Sex	SSN
Address			County	
City	State	Zip	Date of Birth *(mm/dd/yyyy)*	
Home Telephone	Work Telephone		Cell Phone	
Other Contacts				
Insurance No. 1 *(fax photocopy of insurance card)*	Policy No.	ID No.	Subscriber	Benefit Contact
Insurance No. 2 *(fax photocopy of insurance card)*	Policy No.	ID No.	Subscriber	Benefit Contact

Medical Information

Diagnosis *(Primary, then Secondary)*

Allergies ☐ None known ☐ Yes (please specify) ______

Please fax the following information:
- ☐ Most recent history and physical or nephrology note (within last 6 months).
- ☐ List of current medications.
- ☐ Most recent labs, cardiac testing, kidney biopsy, chest x-ray, and CT scans.
- ☐ Colonoscopy (within 5 years). If patient is 50 or older, include pathology reports.
- ☐ Mammogram (within past year) and current Pap Smear report.

AHCCCS Insured: The following medical information is needed before the patient can be referred for transplant evaluation.
- ☐ **All**: CBC, CMP & UA (within 3 months); history and physical (within 3 months); HIV and HCV labs (within past year)
- ☐ **Females, 17 and older**: as above, including current Pap Smear report
- ☐ **Females, 40 and older**: as above, including Mammogram (within past year)
- ☐ **Males, 50 and older**: as above, including PSA (within past year)

*****If on dialysis, 2728 enrollment form MUST BE included at the time of referral.***** ☐

Dialysis	Dialysis Days	Considering Pancreas Transplant?		Diabetes	If diabetic, age of onset.
☐ Yes ☐ No	Su M T W T F Sa	☐ Yes ☐ No		☐ Yes ☐ No	______
Require insulin? ☐ Yes ☐ No	Diagnosis date of ESRD Date ______	Oxygen ☐ Yes ☐ No	Special Needs? ☐ Yes ☐ No	Height ______	Weight ______

Name of External Dialysis Center	Address	Phone

Was the patient transplanted previously? ☐ Yes ☐ No
If yes, date ______ If yes, previous dialysis type (PD or HD) ______

Is the patient currently listed elsewhere? ☐ Yes ☐ No
If yes, location ______ date listed ______

MCS7657-03rev0916