Charleston Area Medical Center

RENAL TRANSPLANT

General Hospital
PO Box 1393
Charleston, WV 25325
1-800-346-6233 (304) 388-7823
Fax: (304) 388-7820

To Whom It May Concern:

In order to expedite patient care we have changed our referral process. We feel this change is necessary in order to provide the best possible care to our patients.

Enclosed with this letter you will find a list of the items we are requesting for each referral, a copy of our guidelines for selection criteria for renal transplantation and a new patient referral form. Please be sure to use the check list and the new patient referral form provided as a Master Copy for future referrals. We ask that you complete the new patient referral form in its entirety so that we may expedite the referral process. The asterisked (***) items on the check list MUST be included in the referral. If we receive an incomplete referral we will provide you with a list of the documentation needed. No appointment will be scheduled without a complete referral.

Your cooperation in this matter is greatly appreciated. As always, if you have any questions, concerns or need further assistance please do not hesitate to contact the transplant office at the above number.

Sincerely,

Renal Transplant
Charleston Area Medical Center

Version 07/29/2016

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Subject: Transplant referrals

Please note our referral forms have changed. In order to expedite the referral process, please remember to include the items listed below when referring a patient to CAMC Renal Transplant.

___ Front sheet (CAMC referral form) ***
___ 2728 Form (If patient is on dialysis) ***
___ Insurance Information (must submit copy of card front and back) ***
___ Laboratory Results: CBC, Chemistries, HgbA1C, Hepatitis panel (last 2 months) ***
___ Medication List ***
___ ABO (blood typing)
___ Native Kidney Biopsy Report if available
___ History & Physical***
___ Discharge Summary
___ Procedures/OR Reports/Any pathology reports
___ Chest X-Ray/EKG, Echocardiogram, Stress Test, Colonoscopy, Ultrasounds
___ Mammogram and Pap smear (female patients only)
___ Nursing History *** (if on dialysis)
___ Nutritional History*** (if on dialysis)
___ Social Service Summary*** (if on dialysis)

Dialysis run sheets are not needed unless there are issues with compliance.

Please feel free to contact us should you have any questions or concerns or need further assistance. Your cooperation in this matter is appreciated.

***Information must be received prior to patient being scheduled. **We are unable to process the referral without this information.**

Thank you!

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NEW PATIENT REFERRAL

*Patient Name-Last: _____ *First: _____ MI: _____

*Date of Birth: _____ *Social Security Number: _____ Marital Status: _____

*Address: _____ *City, State, Zip: _____

*Phone: (_____) _____ Alternate Phone: (_____) _____

*Height(**cm**): _____ *Weight(**kg**): _____ *Nephrologist: _____

*ESRD Secondary to: _____ *Dialysis Center: _____

Date first dialysis: _____ Type of dialysis: (HD, PD, N/A) Days of Dialysis (M/W/F or T/T/S)

*Primary Insurance: _____ Secondary Insurance: _____
***Please attach a legible copy of insurance cards**

Has the patient been previously evaluated for or transplanted at another facility? If yes, where? When? And what organ? _____

Please list the names of any physicians the patient is currently seeing:

Cardiologist: _____ Vascular Surgeon: _____

Gastroenterologist: _____ Neurologist: _____

General Practitioner: _____ Gynecologist: _____

Other Specialist: _____ Other: _____

If the patient has had any of the following tests, please send results with referral or list when and where each test was completed:

Stress Test _____ Echocardiogram _____

Cardiac Catheterization _____ Vascular Studies _____

Colonoscopy _____ EKG/CXR/US _____

Please list the hospital that the patient would prefer to go to for testing: _____