Virginia Mason Franciscan Health™

1100 9th Ave
Seattle, WA 98101
Mail Stop C1-TX
206-341-0925
800-354-9527 Ext 10925

RENAL & PANCREAS TRANSPLANT REFERRAL REQUEST FORM

Thank you for referring your patient to Virginia Mason Medical Center. This form is to be completed by the referring provider or designee. Please fax the **completed form** and most **current H/P** to fax **206-341-0114.**

REFERRING PHYSICIAN

Name (last, first):_____ Date: _____

Office Contact Name & Phone #: _____

Proposed type of transplant ☐ Kidney ☐ Kidney/Pancreas ☐ Pancreas Alone

PATIENT INFORMATION

Name (last, first, middle): _____

Preferred Pronouns: ☐ They/ Them/ Theirs ☐ She/ Her/ Hers ☐ He/ Him/ His Sex ☐ M ☐ F

Mailing Address: _____

Home Phone_____Work Phone: _____Cell Phone: _____

DOB: _____ SS#: _____

Language (If not English): _____Interpreter Needed ☐ Yes ☐ No

Medical Spokesperson (If applicable): _____Relationship: _____

MEDICAL HISTORY

Previous Transplant ☐ Yes ☐ No If yes, Date: _____ Transplant Center: _____

Primary Diagnosis: _____

Dialysis ☐ Yes ☐ No Start Date: _____ Dialysis Unit: _____

Mode ☐ Hemodialysis ☐ CAPD ☐ CCPD

Recorded GFR value of ≤ 20: _____mL/min Date: _____ ☐ No GFR ≤ 20 recorded

If applicable, please print lab result and fax with referral.

INSURANCE

Primary Insurance: _____ Subscriber Name: _____

ID #: _____ Phone #: _____

Secondary Insurance: _____ Subscriber Name_____

ID #: _____ Phone #: _____