Kidney Transplant Program

Please use this fax cover to refer your patients.
Attach required information and fax to:
KIDNEY TRANSPLANT
(F) 602.798.0463

Completed By/Phone-Fax #s _____

_____

Referring MD _____

Referral Date _____

Patient Name _____

DOB _____

Diagnosis _____

Minimum Required Documentation

- ❑ Provider Contact Information
- ❑ Demographic/Face Sheet Information
- ❑ Insurance Card (front/back)
- ❑ History & Physical (HT, WT, Social Support, Social History any past/ present use of tobacco, alcohol, and drugs)
- ❑ Current Labs
- ❑ GFR, results of <20, for preemptive transplant referral
- ❑ HbgA1C (within 90days, if Diabetic)
- ❑ Diagnostic Testing: Radiology, Operative, Pathology, Cardiology

❑ Dialysis ❑ Yes ❑ No

❑ Copy of Medicare Form 2728

❑ Dialysis Type ❑ Hemo ❑ PD Start Date _____

Dialysis Center _____

Phone Number _____

Fax Number _____

Kidney Transplant Program
500 W. Thomas Road, Suite 300
Phoenix, AZ 85013

For information regarding the Kidney Transplant Program at St. Joseph's Hospital and Medical Center, call 602.406.8452.

Thank you for allowing our team to participate in the care of your patients.

Dignity Health.
St. Joseph's Hospital and Medical Center

10/2017
DHAZE4148