UHealth Jackson

Miami Transplant Institute

Transplant Patient Referral Form:

- ☐ Kidney Transplant
- ☐ Kidney-Pancreas Transplant
- ☐ Pancreas

Patient Name: _____ DOB _____
First *MI* *Last* *(mm/dd/yyyy)*

SSN: ____ - ____ - _____ Race: _____ Sex: _____ Height: _____ Weight: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Referring Physician: _____ Phone #_____ _____

Referring MD Email: _____

Referring Dialysis Unit: _____

Office Phone: _____Fax #: _____

Dialysis: ☐ Yes ☐ No Does the patient have any Potential Living Donors? ☐ Yes ☐ No

Treatment Modality: ☐ HD ☐ PD Dialysis Schedule: ☐ M/W/F ☐ T/T/S

Requested Records:

- ☐ Insurance Card
- ☐ History & Physical
- ☐ Current/Last Labs
- ☐ 2728 Form
- ☐ Immunization Records
- ☐ Diagnostic Testing *(If available)*
- ☐ Radiologic Studies/ Imaging *(If available)*

VERY IMPORTANT

Send images to Power Share

(Search Jackson Health System Diagnostic Imaging-Radiology)

or send CD to:

MTI Kidney Program, ATTN: Office Manager

1801 NW 9th Ave, 5th Floor, Miami, FL 33136

PRIMARY INSURANCE INFORMATION: (Please provide a copy of the front and back of card)

Insurance Company Name: _____

Please return this form via fax or email.

1801 N.W. 9th Avenue
Miami, FL 33136

www.MiamiTransplant.org

Office: 305-355-1684
Fax: 305-355-5368
Email: MTI-Kidney-Referrals@jhsmiami.org