



Kidney Transplant Referral

Patient Information

Patient Name _____ **DOB** _____ **Gender** _____
Phone _____

Physician Information

Nephrologist _____
Phone _____ **Fax** _____

Please send records below if available:

- Patient authorization form
- Copy of insurance cards and prescription cards
- Patient demographic information
- Form 2728
- Labs (most recent)
- History and physical (most recent)

Referral information

Dialysis center _____
Office phone _____ **Office fax** _____
Type of dialysis _____ **Start date** _____
Dialysis days **Mon** **Tues** **Wed** **Thurs** **Fri** **Sat**

Insurance Information

Please fax insurance and prescription cards to: 816-932-3973 (KC); 316-303-1026 (Wichita)

If cards are not available, please fill out the following:

Primary _____ **Secondary** _____
Card holder _____ **Card holder** _____
Phone _____ **Phone** _____
ID # _____ **Group #** _____ **ID #** _____ **Group #** _____

Find this form at SaintLukesKC.org/Kidney-Referral