CMC Transplant Center
P.O. BOX 32861
Charlotte, NC 28232
Phone: 800-562-5752, option 4
704-355-3855
Fax: 704-446-4876 or -4875
(Please fax referrals if < 20 pages)

Carolinas HealthCare System

Referral Date: _____

☐ **Kidney**

☐ **Kidney-Pancreas**

=Fill in all blanks=

Referring Nephrologist: _____ Nephrologist Signature: _____
Please PRINT *Please* SIGN

Practice Name: _____ Contact Person: _____
Nephrologist Office or Dialysis Unit *Referral completed by*

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ E-mail: _____

PATIENT Legal Name: _____
Last *First* *MI*

SS#: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

Sex: ☐ M ☐ F Marital Status: ☐ M ☐ S ☐ D ☐ W U.S. Citizen: ☐ Yes ☐ No

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other_____

Language Barrier: ☐ No ☐ Yes If Yes, Primary Language: _____

INSURANCE ☐ Medicare ☐ Medicaid ☐ Other: _____

** *Please include LEGIBLE copy of FRONT and BACK of all insurance and prescription cards* **

EMERGENCY CONTACT Name: _____ Relationship: _____

Phone: _____

For patient's protection and in accordance with the HIPAA Privacy Act - Please answer the following:

☐ Yes ☐ No I (patient) give permission for Kidney Transplant Dept. at Carolinas Medical Center to leave a detailed message on my voice mail.

☐ Yes ☐ No I (patient) give permission to discuss my medical condition with my emergency contact listed above.

Patient Signature: _____ Date: _____
Please SIGN

PATIENT NAME: _____ DOB: _____

MEDICAL INFORMATION

ESRD/CKD SECONDARY TO: _____

DIALYSIS: Modality: ☐ HEMO ☐ HOME ☐ CCPD ☐ CAPD ☐ Pre-Dialysis CKD

Days: ☐ M/W/F ☐ T/TH/S Shift: ☐ 1st ☐ 2nd ☐ 3rd

*** Please include LEGIBLE copy of Medicare Form 2728 if on dialysis ***

Height: _____ inches Weight: _____ ☐ kg ☐ lbs.

Hospitalization within Last 12 Months: ☐ No ☐ Yes If Yes, Where: _____

Previous Transplant: ☐ No ☐ Yes If Yes, When/Where: _____

Smoker: ☐ Yes ☐ No Potential Kidney Donors: ☐ Yes ☐ No

Allergies: _____

PSYCH/SOCIAL HISTORY

Home Situation:

☐ Lives with significant support person
☐ Lives alone
☐ Lives in a nursing home or assisted living

Transportation:

☐ Never or rarely has difficulty with transportation to dialysis
☐ Misses treatments because of no transportation

Compliance:

☐ Takes medicines as directed
☐ Misses medicines frequently
☐ Misses treatments: _____ times per month
☐ Signs off early from dialysis: _____ times per month
☐ Follows dietary and fluid requirements within reason
☐ Frequent hospital admits secondary to noncompliance

Finances:

☐ Has difficulty making ends meet and cannot pay bills
☐ Has stopped taking medications before due to inability to pay

Substance Use:

☐ DWI or drug related conviction
☐ Suspected of IV or other drugs use, type: _____
_____
☐ Suspected of ETOH abuse

Special Needs:

☐ Blind ☐ Prosthesis ☐ Walker
☐ Illiterate ☐ Wheelchair ☐ O_2

Other:

☐ History of depression or mental illness
☐ Currently on antipsychotic or antidepressant.
Agent/drug name: _____
☐ Known felony conviction/incarcerated within 12 months

Comments: _____

Carolinas HealthCare System

Authorization for Release of Health Information

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider; the released information may no longer be protected by federal privacy regulations.

Patient Name:_____
First Middle / Maiden Last

Social Security #:_____ **Date of Birth:**_____

The following individual / organization are authorized to release the requested health information:
Name:_____ **Address:**_____

Telephone Number:_____ _____

Please note the date(s) of service being requested: From: _____ **To:** _____
Please check the specific information being released (used or disclosed):

- ☐ History and Physical
- ☐ Discharge Summary
- ☐ Consultation Report
- ☐ Operative Report
- ☐ Emergency Room Record
- ☐ Clinic Notes: _____
- ☐ Progress Notes
- ☐ Radiology / Imaging Reports
- ☐ Laboratory / Pathology Reports
- ☐ Physician Orders
- ☐ Medication Records
- ☐ Immunization Records
- ☐ Psychiatric Evaluation
- ☐ Other specify):_____
  _____

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

This information may be released to and used by the following individual / organization:
Name **Address: Carolinas Medical Center/Transplant Center**
P O Box 32861 Charlotte, NC 28232

Telephone Number: (704) 355-6649/ (800)562-5752 **Fax (704) 355-7616**

Will the health care provider requesting the authorization receive any financial or in-kind compensation in exchange for using or disclosing the health information described above? ☐ Yes ☐ No

Purpose of Disclosure:
☐ Medical Review ☐ Legal Review ☐ Insurance Review ☐ Personal Use ☐ Other:_____

I understand that I have a right to revoke this authorization at any time by notifying the Medical Record Department of the providing organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this private health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or obtain a copy the information to be used or disclosed.

****Printed Name:**_____ **Signature:**_____ **Date:**_____
(Patient / Authorized Representative)

If Authorized Representative, please indicate relationship to patient:
☐ Spouse ☐ Parent ☐ Other:_____

*Please note, if information relating to the treatment of drug or alcohol abuse is being released, for a patient under the age of 18, the patient must also sign this authorization. **Signature of Minor:**_____

FOR CAROLINAS HEALTHCARE SYSTEM USE ONLY
☐ Identification verified ☐ Copy of Authorization given to patient **Medical Record #:** _____

CHS Employee: _____ Patient Addressograph/ Label

TRANSPLANT REFERRAL CHECK OFF LIST

PLEASE INCLUDE WITH REFERRAL:

- ☐ Legible copy of BACK and FRONT of all insurance and prescription cards
- ☐ MEDICARE FORM 2728 (if on dialysis)
- ☐ Patient's Signature in 2 places:
  - ☐ Page 1 HIPAA Privacy Act
  - ☐ Page 3 Authorization for Release of Health Information – Only Section [**] Signature: _____
- ☐ History and Physical (within 1 year)
- ☐ Current List of Medications
- ☐ Current Labs results
- ☐ Nutritional Assessment (within 1 year)
- ☐ Psych/Social Assessment (within 1 year)