Atrium Health Transplant Center,
a facility of Carolinas Medical Center
PO Box 32861, Charlotte, NC 28232
Phone: 800-562-5752; 704-355-3855
Fax: 704-446-4876; 704-446-4875

Atrium Health

Referral Date: _____
☐ **Kidney** ☐ **Kidney-Pancreas**

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY TO EXPEDITE EVALUATION

Referring Nephrologist: _____ **Nephrologist Signature:** _____

Dialysis Unit: _____ **Contact Person:** _____

or

Nephrologist office if pre-dialysis: _____ **Email:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

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

SS#: _____ **Gender:** ☐M ☐F **Marital Status:** ☐M ☐S ☐D ☐W **Race:** _____

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

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Language: _____ **Interpreter:** ☐Yes ☐No **US Citizen:** ☐Yes ☐No

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

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

☐ Yes ☐ No I (patient) give permission for Kidney Transplant Dept. at Atrium Health 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:** _____

INSURANCE: ☐ Medicare ☐ Medicaid ☐ Other: _____

MEDICAL INFORMATION **Cause of Renal Disease:** _____ **Ht:** _____ **Wt:** _____

Previous Transplant: ☐Yes **When/Where:** _____ ☐No **Potential Living Donor:** ☐Yes ☐No

DIALYSIS: Modality: ☐HEMO ☐HOME HEMO ☐CCPD ☐CAPD **DAYS:** ☐MWF ☐TThS **SHIFT:** ☐1 ☐2 ☐3 ☐PRE-DIALYSIS

Compliance: Misses Treatments a Month: _____ **Early Signoffs a Month:** _____ **Misses Medications:** ☐Yes ☐No

Allergies: _____ **Recent Hospitalization: When/Where:** _____

Diabetes: ☐Yes ☐No **Tobacco Use:** ☐Yes ☐No **HIV:** ☐Yes **ID Physician:** _____ ☐No

Special Needs: ☐Wheelchair ☐Prosthesis ☐Walker ☐Oxygen ☐Blind ☐Illiterate ☐Deaf

Comments: _____

REQUIRED DOCUMENTATION MUST BE INCLUDED WITH REFERRAL

- ☐ Insurance Cards: Legible front and back image
- ☐ History and Physical (within 1 year)
- ☐ Labs (within 3 months)
- ☐ Current List of Medications
- ☐ PPD Results
- ☐ Medicare Form 2728
- ☐ Nutritional Assessment
- ☐ Psych/Social Assessment

Atrium Health

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 healthcare 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: Atrium Health Transplant Center,**
a facility of Carolinas Medical Center
PO Box 32861, Charlotte, NC 28232

Telephone Number: 704-355-3855/ 800-562-5752 **Fax: 704-446-4876**

Will the healthcare 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 ATRIUM HEALTH USE ONLY

☐ Identification verified ☐ Copy of Authorization given to patient **Medical Record #:** _____

Atrium Health Employee: _____ Patient Addressograph/ Label