Revised 2011

Carolinas Medical Center
www.carolinasmedicalcenter.org

KIDNEY TRANSPLANT REFERRAL FORM DATE: _____

TRANSPLANT CENTER
P.O. BOX 32861
CHARLOTTE, NC 28232
800-562-5752 or 704-355-6649 FAX: 704-355-7616

From: Dr._____(*First, Last - Please Print*) MD*Signature* _____

_____(*Nephro.Office or Dialysis Unit*) Provider # _____

_____ ___(*Address*) Telephone # (_____)_____

_____(*City, State, Zip*)) Contact Person _____

☐ KIDNEY ☐ KIDNEY-PANCREAS

Patient Legal Name: _____
Last *First* *Middle I.\Maiden*

Address: _____
City *State* *Zip Code*

Home Telephone: (_____)_____ Cell Phone ( ) _____

Social Security #: _____ Date Of Birth _____

Please Circle One in Each Category:

Sex: M F Marital Status: M S D W Race: White Native Indian Black Hispanic Asian Other_____

Language Barrier: NO YES If Yes: What is their Primary Language?_____

Religion: _____ County Patient Resides In: _____

EMERGENCY CONTACT: Name: _____ Relationship to Patient: _____

Telephone (_____)_____

For your 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 your voice mail.

□ Yes □ NO I give permission to discuss my medical condition with my emergency contact listed above.

Patient Signature: _____ DATE: _____

Insurance: □ Medicare □ Medicaid Other: _____

**** Please include Front & Back Copies of all Insurance Cards and Prescription Cards ****

PATIENT NAME: _____ DATE OF BIRTH: _____

Medical Information

ESRD/CKD SECONDARY TO: _____

DIALYSIS: □ Yes □ NO Date of 1st Dialysis_____

Current Modality: □ HEMO □ HOME □ CCPD □ CAPD Current Access Site: _____

DIALYSIS DAYS: □ M/W/F □ T/TH/S SHIFT: □ 1st □ 2nd □ 3rd

HEIGHT: _____(inches) WEIGHT: _____ □ **Kg** □ **lbs**

PREVIOUS TRANSPLANT: □**Yes** □ **No** If YES; When/Where: _____

SMOKER: □Yes □ No

ALLERGIES: _____ POTENTIAL KIDNEY DONORS: □Yes □ No

Psych/Social History:

HOME SITUATION ☐ Patient lives with significant support person ☐ Patient lives alone ☐ Patient has difficulty reading and writing ☐ Patient requires any medical equipment, i.e., walker, O_2 ☐ Patient lives in a Nursing home or Assisted Living	TRANSPORTATION ☐ Patient never or rarely has difficulty with transportation to dialysis ☐ Patient has missed treatments because of no transportation FINANCES ☐ Patient has difficulty making ends meet and cannot pay bills ☐ Patient had stopped taking medications before because of inability to pay
COMPLIANCE ☐ Patient takes medicines as directed ☐ Patient has missed medicines frequently ☐ Patient misses treatments _____ times per month ☐ Patient signs off early from dialysis: _____ times per month ☐ Patient follows dietary and fluid requirements within reason ☐ Frequent hospital admits 2nd to noncompliance	SUBSTANCE USE ☐ Patient has had a DWI or drug related conviction ☐ Patient suspected of use of IV or other drugs, type:_____ ☐ Patient suspected of ETOH abuse
OTHER ☐ Patient has history of depression or mental illness ☐ Patient is currently on antipsychotic or antidepressant. Agent/drug name:_____ ☐ Patient has a known felony conviction/incarcerated within 12 months	

Comments: _____

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

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:

☐ History and Physical (Must be within one year)

☐ Nutritional Assessment

☐ Psycho-Social Assessment

☐ PPD results (within one year)

☐ Letter of Medical Necessity from Referring MD

☐ Current List of Medications

☐ Current Labs Results

☐ Hospitalization Records for last 12 months including H&P and Discharge Summary, any Cardiac Records
OR Name of Medical Center Patient has been admitted to in the last 12-24 months _____

☐ Legible copies of back and Front of INSURANCE CARDS

☐ Patient's Signature: TWO PLACES

1. Consent to Leave a voice mail message & HIPAA Contact Information
2. Release of Medical information (Pg 3) –Only Section [**] Signed By Patient