Adult Kidney/Pancreas Transplant External Intake Form

Phone number: 352.265.0254 | Fax: 352.627.4410

PATIENT INFORMATION

Date:		E-mail:	
Name:		Phone:	Cell:
Address:			
DOB:	Gender:	Race:	Ethnicity:
Height:	Weight:	BMI:	
Marital Status:		Maiden Name:	
Spouse Name:		Spouse contact number:	
Is interpreter needed?: ☐ Yes ☐ No		Preferred Language:	

Any previous Transplants? ☐ Yes ☐ No, If *yes*, which organ(s): ______

Place of Transplant(s): ______ Date of Transplant(s): ______

REQUESTING FACILITY

Person initiating request:	Phone:
Requesting physician:	NPI#:
Facility:	DSM:
Phone:	Fax:
Address:	
Primary care physician (PCP):	DSM:
Phone:	Fax:
Address:	

DOCUMENTATION TO INCLUDE

REQUIRED:

- ☐ Clear copy of current insurance cards
- ☐ Most recent MD office note
- ☐ Most recent lab work completed
- ☐ Patient demographic/face sheet (or patient information completely filled)
- ☐ Comprehensive medical and surgical history
- ☐ **Medicare 2728** form if on chronic dialysis

INCLUDE IF APPLICABLE:

- ☐ Images of diagnostic reports sent through Nuance Power Share or on CD
- ☐ Cardiac Echocardiogram (all ages) and cardiac stress test if over the age of 35 *(can be obtained during evaluation)*
- ☐ Routine cancer screens: pap smear, mammogram or colonoscopy
- ☐ Diagnostic Reports: ultrasounds, CT scans, MRIs or X-rays
- ☐ Other pertinent records based on medical history such as cardiac, rheumatology, surgical, endocrine and others

Cause of renal disease:

______

______

______

Diabetes ☐ Y ☐ N Dialysis ☐ Y ☐ N

Dialysis Facility: ______

Phone: ______ Fax: ______

Address: ______

Dialysis Type

- ☐ In center HD
- ☐ Home HD
- ☐ CAPD
- ☐ CCPD
- ☐ Other

Schedule *(please check day)*

☐ Su ☐ M ☐ Tu ☐ W ☐ Th ☐ F ☐ Sa

Does the patient have a living donor? ☐ Y ☐ N

NOTE: *If you do not have a Nuance Power Share account, please use our secure link (https://www1.nuancepowershare.com) and generic login (tempphysician@shands.ufl.edu, "Password1"). If sending a physical CD, it should be brought by patients to their first visit.*

Patient Name: Patient Identification #: