BOSTON MEDICAL CENTER

EXCEPTIONAL CARE. WITHOUT EXCEPTION.

BOSTON MEDICAL CENTER KIDNEY TRANSPLANT REFERRAL FORM

Main Telephone number: 617-638-8430 Fax Number: 617-638-8427

Date: _____

Thank you for referring your patient to the Boston Medical Center Kidney Transplant Program for a Kidney Transplant Evaluation.

A Kidney Transplant Evaluation appointment will be scheduled for your patient. They will receive a packet in the mail that will contain the "Kidney Transplantation Manual for Patient Education" along with a copy of the "Informed Consent for kidney Transplant Evaluation" to review before the appointment.

Please send as much of the following information as available so that we may expedite the evaluation process.

- ☐ Patient Demographics, please include insurance information
- ☐ Primary Language: _____
- ☐ Nephrologist Name _____ Tel # _____ Fax# _____
- ☐ Dialysis Center: _____ Tel # _____ Fax# _____
- ☐ Dialysis Days: _____ Dialysis Start Date: _____
- ☐ Most recent clinical note describing patient's kidney disease along with their medical and surgical history
- ☐ Medicare 2728 form
- ☐ PPD results
- ☐ Medication list
- ☐ Cardiac testing results, please include cardiac clinic notes if available
- ☐ Colonoscopy results
- ☐ Mammogram/Pap smear results
- ☐ Most recent lab results

Please call with any questions or concerns!

Karen Curreri RN CCTC
Pre Transplant Coordinator
617-638-8368 desk/voice mail
617-638-8427 fax