TRANSPLANT CENTER

A service of Mercy Medical Center–Des Moines

411 Laurel St., Suite 2310
Des Moines, Iowa 50314
(515) 247-4261
Fax: (515) 643-8870

TRANSPLANT REFERRAL FORM
Mercy Transplant Center | Fax: (515) 643-8870

Directions: Please complete the form in its entirety. Fax the form and all medical records listed at bottom of page to ensure that we can expedite the referral process.

Referring Organization Demographics		
Date form sent:		
Type of Transplant Evaluation Requested: ☐ Kidney ONLY ☐ Kidney/Pancreas ☐ Pancreas Alone ☐ Pancreas after Kidney Transplant		
Name of Referring Person:	Call back number: ( )	
Referring Person Role: ☐ Physician ☐ Dialysis Social Worker ☐ Dialysis Nurse ☐ Self-Referral		
Referring Organization Name:		
Dialysis Unit Name: ☐ *Same as above*		☐ Not applicable
Dialysis Unit Telephone #: ( )	Fax #: ( )	
Physician Name:	Clinic Name:	
Clinic Telephone #: ( )	Fax #: ( )	

Patient Demographics *(please print legibly)*			
First Name:	MI:	Last Name:	
Date of Birth:	SSN:	Height:	Weight:
Address:			
City:	State:	Zip Code:	
Primary Phone: ( ) home/cell	Secondary Phone: ( ) home/cell/work		
Does patient speak English: ☐ Yes ☐ No	If no, primary language:		

Patient Medical Information			
ESRD Diagnosis:	Diabetes: ☐ No ☐ Yes, Type: ☐ Type I ☐ Type II		
Receiving dialysis:	☐ No ☐ Peritoneal Dialysis ☐ Hemodialysis, ☐ M/W/F ☐T/Th/S ☐ AM ☐PM		
If *not* receiving dialysis	Creatinine level:	Date obtained:	GFR:

Patient Insurance Information *(please fax front and back of current cards with medical records)*	
Primary Insurance:	ID#:
Secondary Insurance:	ID#:

Please fax this completed referral form along with the information below to the transplant office:

1. Demographic page or information
2. Insurance cards (front & back)
3. Most recent history and physical
4. Current medication list
5. Most recent set of labs, include C-Peptide if pancreas referral
6. All diagnostic tests (cardiac, pulmonary, cancer screening, etc.)
7. Record of immunizations and TB test
8. For Patients receiving dialysis:
   - 2728 Form & Dialysis Plan of Care
   - 90-day attendance record
   - Social Worker notes

6031-089 6-12-18

Office Use Only – Records Received Date:_________________