MAYO CLINIC

Referring a Patient to: Kidney/Pancreas Transplantation Program Program at Mayo Clinic

Please fax this form to: (480) 342-0555
For questions, please call: (480) 342-1010
Thank you for referring your patient to Mayo Clinic.

Referring Physician Information

Referring Physician's Name *First*	*Last*		Date *(mm/dd/yyyy)*
Office Address			UPIN No.
City	State	Zip	Telephone
Reply to Fax No.	Contact Person		

Patient Information

Patient Name *First*	*Middle Initial*	*Last*	Sex	SSN
Address			County	
City	State	Zip	Date of Birth *(mm/dd/yyyy)*	
Home Telephone	Work Telephone		Cell Phone	
Other Contacts				
Insurance No. 1 *(fax photocopy of insurance card)*	Policy No.	ID No.	Subscriber	Benefit Contact
Insurance No. 2 *(fax photocopy of insurance card)*	Policy No.	ID No.	Subscriber	Benefit Contact

Medical Information

Diagnosis *(Primary, then Secondary)*

Please fax the following information:

- ☒ Most recent history and physical or nephrology note (within last 6 months).
- ☒ List of current medications.
- ☒ Include most recent labs and cardiac stress test, psychosocial evaluation, kidney biopsy, echocardiogram, chest x-ray.
- ☐ Colonoscopy (within 5 years). If patient is 50 or older, include pathology reports.

AHCCCS Insured: The following medical information is needed before the patient can be referred for transplant evaluation.

- ☐ **All**: CBC, CMP & UA (within 3 months); history and physical (within 6 months); HIV and HCV labs (within past year)
- ☐ **Females, 17 and older**: as above, including current Pap Smear report
- ☐ **Females, 40 and older**: as above, including Mammogram (within past year)
- ☐ **Males, 50 and older**: as above, including PSA (within past year)

Dialysis	Dialysis Days	Considering Pancreas Transplant?	Diabetes	If diabetic, age of onset.
☐ Yes ☐ No	Su M T W T F Sa	☐ Yes ☐ No	☐ Yes ☐ No	_____

Require insulin?	Diagnosis date of ESRD	Oxygen	Special Needs?	**Height**	**Weight**
☐ Yes ☐ No	Date _____	☐ Yes ☐ No	☐ Yes ☐ No	_____	_____

Name of External Dialysis Center	Address	Phone

Was the patient transplanted previously? ☐ Yes ☐ No
If yes, date _____ If yes, previous dialysis type (PD or HD) _____

Is the patient currently listed elsewhere? ☐ Yes ☐ No
If yes, location _____ date listed _____

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