Children's Hospital of Wisconsin
Froedtert & Medical College of Wisconsin
TRANSPLANT CENTER

FAX COMPLETED FORM TO (414) 805-4343
Any questions: Refer to
www.froedtert.com/transplant or
call (414) 805-6400

Kidney or Pancreas Transplant Patient Referral Form

Patient Information **Date:** _____

Patient Name:_____**Gender: Male Female (circle one)**

Patient Address:_____**City:**_____

State:_____**Zip Code:**_____**Date of Birth:** _____

Primary Care Provider (Name/Address/Phone/Fax):_____

Interpreter needed? Yes / No (circle one) **Language:** _____

Is the patient a US Citizen? Yes No If no: Resident Alien or Non-Resident Alien

[Note: Patient will need to provide documentation regarding legal status in the U.S. prior to the scheduling of an evaluation for transplant.]

Does the patient have an active power of attorney? If so, name of contact_____

Best time to contact patient or representative: morning afternoon (circle one)

Primary phone #:_____**Secondary Phone #:**_____

Primary Insurance (Company, ID#, Group#) _____

Secondary Insurance (Company, ID#, Group#) _____

Type of transplant referral (Organ-specific):_____

Primary Disease (reason for organ failure):_____

If the patient has received a previous transplant, please list the organ, date of transplant and transplant center:

_____

If the patient is currently on the transplant waitlist at another center, please list transplant center and date of listing:

_____

Referring Provider:

Clinic Name: _____

Provider Name: _____

Address: _____

City:_____**State**_____**Zip code:** _____

Phone & Fax #: _____

If on Dialysis: Type: Hemo Peritoneal

Start Date:_____**Schedule: MWF TTHS**

Contact Person: _____

Unit Name: _____

Address: _____

Unit Phone & Fax:_____