HALIFAX HEALTH

CENTER FOR TRANSPLANT SERVICES

311 N. Clyde Morris Blvd., Suite 360, Daytona Beach, FL 32114

(386) 425−4650 • Fax (386) 425−7510

CANDIDATE REFERRAL FORM

MRN: _____ (office use only)

Race: _____

Email: _____

Language: _____

Occupation: _____

Referral Date:_____ Referral Source: ❑ MD ❑ Dialysis Center ❑ Self ❑ Other: _____

Patient Name:_____ Date of Birth: _____

Social Security Number: _____ Sex: ❑ Male ❑ Female Marital Status: _____

Home Address:_____

Home Phone: _____ Work Phone: _____

Cell Phone:_____ Primary Care MD: _____ Phone:_____

Nephrologist:_____ Dialysis Center:_____

Nephrologist Phone #:_____ Dialysis Phone #: _____

Cause of Renal Disease :_____ (Medicare 2728 form required if on dialysis)

Initiation of Dialysis:_____ Diabetic: ❑ Yes ❑ No Onset Age: _____

Please circle: Peritoneal / Hemodialysis Schedule: SU M TU W TH F SA ❑ AM ❑ PM

If preemptive, GFR value/date: _____ Height: _____ (cm) Weight: _____ (kg) BMI: _____

Primary Insurance:_____ ID Number:_____

Secondary Insurance:_____ ID Number:_____

Are you receiving assistance paying for your premiums? ❑ Yes ❑ No

Prior Transplants? ❑ Yes ❑ No Organ Type/Year: _____

Prior/Current Cancer ❑ Yes ❑ No Type/Year: _____

Oxygen Status: _____ HIV Status: _____ Smoking Status: _____

Medical / Social Concerns: _____

Dialysis Social Worker: _____ Contact #: _____

** Please send the required information listed below to Halifax Health Center for Transplant by mail or fax.

**The patient will be contacted by our office to schedule an appointment AFTER the records have been recieved and reviewed.

Mandatory Records Requested for Referral Entry:

❑ Copy of insurance cards, front and back or write policy and claims number on separate sheet of paper.
❑ Current history and physical within the past 12 months, referral CANNOT be processed without current H&P
❑ Recent labs, PSA if age 50 and older
❑ Psychosocial evaluation/social work assessment
❑ Medicare 2728 form if on dialysis
❑ Special authorization to release information consent
❑ Physician Healthcare Sheet
❑ Vaccination reports
❑ Dialysis rounding report

Testing required for evaluation, please include current reports, if available:

❑ Cardiac stress test, if over age 35, and cardiac echo on all candidates
❑ Routine cancer screens: Pap smear, mammogram, colonoscopy (as recommended by the ACS).
These are not part of the transplant evaluation and are required for acceptance.
❑ Provide any pertinent records based on medical history, example: Rheumatology, surgical, endocrine, and others

If reports available from within the past 6 months:

❑ Chest X−ray
❑ EKG