Pediatric Kidney and Liver Transplant

Phone: 843-792-5097
Fax: 843-792-1709

After Hours: MEDULINE 800-922-5250
MUSChealth.org

Referral Form: Pediatric Kidney or Liver Transplant

Patient Name:________________________ SS#_______________ DOB: _______ Gender: _____

Address: ______________________________ City________________ State____ Zip: _______

Email address:______________________________ Best Contact Number:_____________________

Emergency Contact:_________________ Phone:_______________Relationship:____________

Prior Evaluation for Transplant? If Yes, Where:___________________________

When:_______________

Referring Physician:______________________________

Phone Number:__________________________ Fax Number:________________________________

Prior Transplant: Yes______ Center name: ___________________ Donor/UNOS ID: _____________

Name of Person Completing this form:______________________ Contact Number:_______________

Please include any or all of the following documents (if available) with this form:

Insurance Cards (Front and Back of cards) and/or Medical Facesheet
Immunization Record
Most Recent Office Visit note
Hospital Discharge Summary (If hospitalized in the last year)
History and Physical with name of Primary Care Provider
Dialysis Information
ECG
Echocardiogram Report (Most Recent)
Biopsy/Pathology reports
Rejection History
Operative Reports from any abdominal surgeries
Recent Labs (including ABO/Blood Type)
Radiology Reports: Chest X-Ray, MRI, CT, Ultrasound
Health Maintenance: Dental Screening, PAP Results

FAX TO:
843-792-1709