PRESBYTERIAN

Transplant Services
Recipient Intake Form

Please read before completing this form

This from is intended for referrals of potential transplant recipients.

You may complete this form, to the best of your ability, and mail or fax to Presbyterian Transplant Services.

Please use this as the cover sheet when sending completed form.

Address: Presbyterian Transplant Services.
201 Cedar Ave SE, Suite 820
Albuquerque, NM 87106
Fax number: (505)563-6137

If you would like to speak with a Transplant team member before completing this form, or if you need assistance completing it, please call **(505) 841-1434**. Once we receive the completed form, a Transplant team member will contact the patient to complete the referral process.

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□ Kidney
□ Kidney/Pancreas
□ Pancreas Only

Demographics

Referral Date:		Referral Type: □ Self □ Family □ MD □ Dialysis	
Patient Name:			
DOB:		SSN:	
Sex:	Height:	Weight:	BMI:
Mailing Address:			
City:	State:	ZIP Code:	
Home:	Work:	Cell:	
Primary Language:		E-mail:	
Emergency Contact:		Phone:	
Emergency Contact:		Phone:	
Do we have permission to leave messages on: □ Home □ Cell □ With Others			
Work Status:			
Marital Status:			
Ethnicity/Race:			

Dialysis Information

Type of Dialysis: □ Pre-dialysis □ Hemodialysis □ Peritoneal Dialysis	
Dialysis Start Date:	
Name of dialysis clinic:	
Fistula location on body:	
Days: □ M, W, F □ T, Th, Sa	Time you start:
Cause of kidney disease:	
What is your GFR (Glomerular Filtration Rate)?	
Are you being worked up or are you listed anywhere else? □ Yes □ No If yes, where? _____	

Hospitals and Clinics

Nephrologist (Kidney Doctor):	Phone:
Primary Doctor:	Phone:
Cardiologist:	Phone:
OB/GYN (Women):	Phone:
Other Clinics/Hospitals	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Insurance/Billing Information

Primary Insurance:	Secondary Insurance:
Member/Policy ID #:	Member/Policy ID #:
Group #:	Group #:
Customer Services phone #:	Customer Services phone #:
Insurance verified: □ Date verified: _____	

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Recipient Medical Questionnaire

Are you currently urinating? □ Yes □ No	How many times a day?	
Have you had a transplant before: □Yes □ No Date of Transplant:	Where were you transplanted? What organ?	Do you now or have you ever taken immunosuppression? □Yes □No If yes, what medications? For how long?
Please list any known medical allergies (food, animals, medications, etc.):		
Have you ever had a blood transfusion? □ Yes □ No	If yes, when? How many?	
Are you willing to receive blood products? □ Yes □ No	If no, reason:	
Do you have diabetes? □ Yes □ No	Age or year you were diagnosed:	
Do you have hypertension? □ Yes □ No	Age or year you were diagnosed:	
Have you ever had an echocardiogram? □ Yes □ No	Last one done:	
Have you ever had a stress test? □ Yes □ No	Last one done:	
Have you ever had a heart catheterization? □ Yes □ No	Date:	
Have you ever had tuberculosis? □ Yes □ No	When:	
Have you ever had Hepatitis: □ A □ B □ C □ Never	When:	
Have you had a Hepatitis B vaccine? □ Yes □ No	When:	
Do you have a history of: □ Smoking (cigarettes) □ Vaping □ Alcohol abuse □ Marijuana □ I.V. drug use □Edibles □ Other drug use □ None	Comments: What did you use? For how many years? Quit date/year:	
Are you currently using: □ A wheelchair □ A walker □Prosthetics □ None of these	If yes, how frequently and for how long?	

Women

Last OB/GYN visit:	Last Pap smear:	Last Mammogram:
How many pregnancies?	How many child births?	
Have you ever had a colonoscopy: □ Yes □ No	When was your last one?	

Men

Do you have any prostate problems? □ Yes □ No	What problems do you have (Enlarged prostate)?
Have you had a Prostate-Specific Antigen (PSA) test? □ Yes □ No	When was the last test done?
Have you ever had a colonoscopy? □ Yes □ No	When was your last one?

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Other Information

When was your last dental visit?	Do you have: □ Dentures □ Partials □ Top □ Bottom □ Both
Do you use continuous oxygen? □ Yes □No	
Have you had cancer? □ Yes □ No Date: _____	If so, please explain what type?
Do you have potential donors? □ Yes □ No	Who?

Past Surgical History

Surgery	Date/Location

Additional comments or medical history not covered: