Stanford HEALTH CARE

Adult Kidney and Kidney/Pancreas Transplant Program
750 Welch Road, Suite 200
Palo Alto, CA 94304
Phone: (650) 725-9891; Fax: (650) 723-3997

Evaluation Consultation/Referral Request Form

Patient Information

Full Name: _____ Date of Birth: _____
(Last, First)

Address: _____
Street *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Social Security No.: _____

Height: _____ Weight: _____

Name of Insurance: _____
(Please attach a copy of patient's medical insurance cards with member ID# visible/legible)

Potential living donor? Yes / No Name: _____ Relationship: _____

Patient's Preferred Language: _____

Referring Provider

Consultation/Referral Requested by (Print physician's name): _____

Physician's Signature: _____

Dialysis Facility: _____

Dialysis Schedule: MWF / TThS / Other: _____ Time: _____

Clinic Location

Please indicate the location that you would like your patient to be seen at:

☐ Stanford main campus: Monday – Thursday afternoon (300 Pasteur Dr., Palo Alto 94304)

Or one of our outreach locations (Friday mornings only):

☐ Santa Clara (2518 Mission College Blvd) ☐ Pleasanton (5720 Stoneridge Mall Rd) ☐ Monterey (5 Lower Ragsdale Dr.)

Medical Records

Please fax this referral form and a copy of the patient's most recent medical records to: ***(650) 723-3997***

☐ 2728 Form (incl. social security # and nephrologist's signature)

☐ History & Physical ☐ Office/Clinic/Progress notes ☐ Discharge summary (most recent) ☐ Kidney biopsy

☐ Cardiac studies (e.g. Echo, Stress test, CT abdomen/pelvis)

**Incomplete referrals may cause a delay in processing*