Stanford HEALTH CARE

REFERRAL FORM

Stanford Kidney Transplant Program
725 Welch Rd. Ste 200
Palo Alto, CA 94304
Phone: 650-725-9891 **Fax:** 650-723-3997

REFERRING PROVIDER INFORMATION

Referring Provider (MD, DO, NP, PA): _____

Medical Group: _____ Email: _____

Phone:_____ Fax: _____ NPI: _____

Address: _____

City/Zip Code: _____

☐**Non-ESRD** ☐**ESRD (please fill out below)**

Dialysis Facility: _____

Dialysis Schedule: ☐ MWF ☐ TTHS ☐ Other: _____Time: _____

Dialysis Unit Social Worker: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____

DOB:_____/_____/_____ Gender: ☐M ☐F Phone:_____

SSN: _____

Address: _____

City/ Zip Code: _____

Height: _____ Weight: _____ Needs Interpreter? ☐Y ☐N Language: _____

Potential living donor? ☐ Yes ☐ No / If YES – Relationship of potential living donor: _____

DOCUMENTATION REQUIRED (Please fax with this form):	
☐ **Patient's Insurance Card w/ member ID**	☐ **2728 Form (with SSN# & Nephrologist's signature)**

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☐ **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*

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