Kidney Post-Transplant Referral

Mailing Address:
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AUGUSTA UNIVERSITY
Transplant Program

REQUIRED DOCUMENTS FOR PROCESSING

❑ **Insurance Cards** *(legible copy, front and back)* ❑ **Most Recent Office Note** ❑ **Labs**

❑ **Driver's License or State Issued ID** ❑ **Surgery Records** *(Discharge Summary, H&P, and Transplant Operative Note)*

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____ SSN: _____ Transplant Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

REFERRAL INFORMATION

Referring Physician: _____ Phone: _____

Current Nephrology Physician: _____ Facility Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Transplant Center: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

INSURANCE INFORMATION

❑ Medicare ❑ Medicaid ❑ VA ❑ Commercial

Primary Insurance: _____ Prescription Plan: _____

Secondary/Tertiary Insurance: _____

Employment: ❑ Working ❑ Not Working ❑ Retired

FOR AU TRANSPLANT CENTER USE Received by: _____ Date/Time: _____