

Thank you for referring your patient to the Kidney & Pancreas Transplant Program at Virginia Mason Medical Center.

Referring Physician: _____

Proposed Type of Transplant: Kidney Kidney/ Pancreas Pancreas AlonePatient Name: _____ DOB: _____ Sex: Male FemaleLanguage if not English: _____ Interpreter Needed? Yes NoPreferred Pronouns: They/ Them/ Theirs He/ Him/ His She/ Her/ HersOn Dialysis? No | If yes – Unit/ Location: _____Mode/ Type: Hemodialysis Home-Hemodialysis PD**Please fax the following documentation for transplant patient candidacy (Required).**

- Patient Demographics (Complete)
- Insurance Information (Insurer, Group #, ID#)
- H & P (within 6 months of this referral date)
- Labs w/ race neutral eGFR (within 6 months of this referral date)
- Immunizations
- Dialysis RD Clinic Note (if on dialysis)

Include the following records with your referral to expedite appointment scheduling.**Reports/ Results** (Most Current Available)

- Renal Biopsy Report
- Cardiac (Testing, Clinic Note)
- Radiology/ Imaging (Abdominal US, CT)
- GI (Colonoscopy, EGD)
- Vascular