Transplant Evaluation Request

ECU HEALTH

Options to Request an Appointment

☐ **Direct Messaging/EHR:** Referral@Direct.VidantHealth.com

☐ **Fax:** 252-847-3337 | **Phone:** 252-847-0097

Referral_____ **MRN #**_____

Please include recent H/P, Form 2728, copy of insurance cards, labs and the physician referral note, if possible. If you have a stat appointment request, it is best to call the physician's office directly. For emergencies, send the patient to the closest Emergency Department.

Referring office_____ Referring office phone_____

Office contact_____ Contact's fax_____

Referring provider_____ Request date_____

Patient name_____ Date of birth_____

Address_____

City_____ State_____ Zip_____

Gender ☐ Male ☐ Female Race_____ SSN_____

Home phone_____ Alternate phone_____

Language ☐ English ☐ Spanish ☐ Other_____ ☐ Need translator

Transplant Services

Patient Days in Dialysis

M	T	W	Th	F	S	Su
☐	☐	☐	☐	☐	☐	☐

Select requested service:

☐ Kidney ☐ Pancreas

Dialysis start date_____

Insurance ☐ *BCBS* ☐ *Medicare* ☐ *Medicaid* ☐ *Medicaid CA* ☐ *Tricare Prime* ☐ *Tricare Select* ☐ *Self-pay* ☐ *Other*_____

Primary insurance #_____ Group #_____

Secondary insurance #_____ Group #_____

Group NPI for authorization_____ Dates covered_____ # visits covered_____

Patient Screening

Height_____ Weight_____ BMI_____

Does the patient smoke? ☐ Yes ☐ No If yes, how much and how long?_____

History of cancer? ☐ Yes ☐ No If yes, what type and when?_____

Use of home oxygen? ☐ Yes ☐ No History of stroke/CVA within the last 6 months? ☐ Yes ☐ No

Is the patient currently on Brilinta? ☐ Yes ☐ No Is the patient wheelchair bound? ☐ Yes ☐ No

Reside in a nursing home or assisted living? ☐ Yes ☐ No Reliable/consistent transportation? ☐ Yes ☐ No

Any other medical issues you would like to tell us about?_____

REFERRAL CENTER USE ONLY	
Appointment date_____	Appointment time_____
Specialist name_____ ☐ MD ☐ DO ☐ NP ☐ PA	

Office name_____ Phone_____ Fax_____

Office address_____

Patient notified by ☐ Phone ☐ Specialty Office ☐ VM ☐ NVM ☐ Mail ☐ New Patient

☐ *Form Completed Internally*