Transplant Evaluation Request

ECU HEALTH

Options to Request an Appointment

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

☐ **EHR:** VMC PRE-TRANSPLANT CLINIC ☐ **Fax:** 252-847-3337

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.

Referral____________________ **MRN #**________________

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*