Adult Abdominal Transplant Center

Patient Referral Form

Contact us
For any patient referral questions, please contact our care team at:
t 512-324-7930 **fax** 833-340-0748

Please select referral type:

❑ Pre-Kidney Transplant ❑ Pre-Pancreas Transplant ❑ Post-Transplant ❑ Transplant Nephrology Consult ❑ Pediatric Transition Consult

Referral date: _____ Referring physician: _____

Practice name: _____

Referring physician's address: _____

Phone number: _____ Fax number: _____

Patient Information

Last name: _____ First name: _____ MI: _____

SSN: _____

Street address: _____

City: _____ State: _____ Zip: _____

Primary phone: _____ Secondary phone: _____

DOB: _____ Race: _____ Gender: _____

Email: _____

Occupation: _____ Language of choice: _____

Emergency contact: _____

Emergency contact phone: _____

Emergency contact relationship to patient: _____

Primary insurance company: _____

Policy number: _____

Secondary insurance company: _____

Secondary insurance policy number: _____

Medical Information

Dialysis center: _____

Address: _____

Dialysis start date: _____

Phone: _____ Fax: _____

Type of dialysis: ❑ HEMO ❑ PD ❑ N/A

Schedule: ❑ (M/W/F) ❑ (T/Th/S)

Cause of renal failure/diagnosis: _____

Height: _____ Weight: _____

Completed by: _____

Required Documentation

- ❑ Primary insurance cards: front and back
- ❑ Secondary insurance cards: front and back
- ❑ Form 2728
- ❑ H&P (within 6 mos.) – if not available, provide hospital discharge, summary, admission
- ❑ Recent labs (within 3 mos.)
- ❑ Completed referral form
- ❑ Medication list
- ❑ Driver's license or other government approved ID

Fax documents to:
833-340-0748

Once we receive the referral patient information requested on this form, the patient will typically be seen within 2-6 weeks. We will also notify the patient regarding appointment date/time, test results, treatment, diagnostic information. We will provide visit notes to your office using the contact information provided above.

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The University of Texas at Austin
UT Health Austin