Transplant Evaluation Request

VIDANT HEALTH™

OPTIONS TO REQUEST AN APPOINTMENT:

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

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

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 _____ **Patient birth date** _____

Patient address _____

City _____ **State** _____ **Zip** _____

Gender ☐ **Male** ☐ **Female** **Race** _____ **Patient SSN** _____

Home phone _____ **Alternate phone** _____

Preferred language ☐ **English** ☐ **Spanish** ☐ **Other** _____ ☐ **Translator needed**

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 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**