LEGACY
HEALTH

LEGACY TRANSPLANT SERVICES REFERRAL CHECKLIST

Please provide all of the information below to initiate the evaluation process. The evaluation will not start until the referral is complete. Please send to:

Deborah Bowers, Intake Coordinator Phone: 503-413-6556 Fax: 503-413-6557
Address: Legacy Transplant Services, 1130 NW 22nd Ave., Suite 400, Portland OR 97210

Referring office:

☐ Name of contact person
☐ Phone number of contact person

Potential Transplant Candidate:

☐ Name
☐ Address
☐ Phone numbers
☐ Date of Birth
☐ Copy of insurance card (front and back)
☐ Weight:_____
☐ Height:_____
☐ Cause of ESRD: : ☐ HTN ☐DM ☐PCKD ☐Other:_____
☐ If not on dialysis, eGFR
☐ If on dialysis, form 2728 and name of dialysis unit
☐ Current problem list

The problems listed below are of particular importance in the decision making regarding the patient's candidacy. If applicable, please provide pertinent details:

Cardiac disease
History of Strokes/TIAs
History of cancer
Psychosocial/behavioral issues/ non-compliance
Substance dependency (contraindicated in the last 6 months, including marijuana)
Refuses blood products
Viral hepatitis
Prior transplants