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
☐ Medication list
☐ Vaccines and immunizations
☐ Recent history and physical (within the last 6 months)

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