



THE UNIVERSITY OF TOLEDO
MEDICAL CENTER

University of Toledo Medical Center
Kidney Transplant Evaluation Worksheet

*****All FIELDS MUST BE COMPLETED*****

Patient Name: _____ Date: _____

Patient Complete Address: _____

Home Phone: _____ Cell Phone: _____

SS#: _____ Birth Date: _____

Ethnicity: _____ Sex: _____

Age: _____ Height: _____ Weight in lbs.: _____ BMI* _____

Nephrologist: _____ Phone: _____

Dialysis Center: _____ Dialysis Center Phone#: _____

Dialysis Days: _____ Date began dialysis _____

Contact Person at Dialysis or Nephrologist Office: _____

Will this be the FIRST transplant YES NO If NO, how many previous _____

Does the patient have a donor: YES NO Does patient need an interpreter YES NO

Is the patient aware they are being referred for transplant evaluation YES NO

The Following Information MUST Be Provided:

- 1) Insurance & Prescription cards- **Copy of Current**
- 2) 2728- **We will not be accepting any referrals (for patients on dialysis) without them**
- 3) Most recent H&P or progress note
- 4) Demographic Sheet
- 5) Medication List- **Most Current**
- 6) Kidney Biopsy

Please Fax to 419-383-6638

**If you have any questions, please call 419-383-6707 or
1-800-321-8383 ext. 6707**