THE UNIVERSITY OF TOLEDO
MEDICAL CENTER

University of Toledo Medical Center
Transplant Evaluation Worksheet

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

Patient Name: _____Date: _____

Patient Complete Address: _____

_____

Best phone number to reach patient: _____--_____--_____ (please circle) Cell , Home

SS#: _____-____-_____ Birth Date: _____ Sex:_____

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

Referral for: ☐ **Kidney only** ☐ **Kidney/Pancreas** ☐ **Pancreas only**

Referring MD: _____ Phone: _____

Dialysis Center: _____ Dialysis Center Phone#:_____

Dialysis Days: _____ Date began dialysis_____

Contact Person at Referral Source: _____

E-mail address for Referral Source: _____

Fax number for Referral Source: _____

Will this be the FIRST transplant YES ☐ NO ☐ If NO, how many previous_____

Does patient need an interpreter 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 (if available)

Please Fax to 419-383-6638

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

7-2024