Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

TRANSPLANT INSTITUTE REFERRAL REQUEST FORM

Thank you for choosing the BIDMC Transplant Institute. We look forward to partnering with you in your patient's care.
Please note which program this is for:

☐ **Liver Transplant** ☐ **Kidney/Pancreas Transplant** ☐ **Dialysis Access Surgery** ☐ **Hepatobiliary Surgery**

Date: _____ # of pages faxed _____

☐ Routine ☐ **URGENT**

Phone: (617) 632-9700 | Fax: (617) 632-9820

Email: TransplantReferrals@BIDMC.harvard.edu

Referring Provider Information:

Referred by (MD): _____ Medical Group: _____

Phone: _____ Fax: _____

Address: _____ City_____ State:____ Zip:_____

Email:_____

Patient Information:

Last Name: _____ First Name: _____ MI:_____

DOB: ____/_____/_____ Gender: ☐ M ☐ F Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Needs Interpreter? ☐ Yes ☐ No Language: _____

Insurer: _____ ID #: _____

Reason for Referral:

Primary Diagnosis/ ICD 10: _____ Secondary Diagnosis: _____

Type of Visit: ☐ **Transplant Evaluation** ☐ **New Dialysis Access** ☐ **HB Surgery Consultation**

Physician Requested:_____

If requested physician is unavailable, can patient be seen by another provider?

☐ Yes ☐ No, contact MD

Documents Required (please send with this form):

- ✓ H&P/Office Note
- ✓ EGD/Colonoscopy (pathology report)
- ✓ Medication/Allergy List
- ✓ Immunization Record
- ✓ Lab Data
- ✓ Imaging Reports/Disk
- ✓ Pathology (biopsy results)
- ✓ Dialysis Records (if applicable)
  - o Run Sheet
  - o Psycho Social Evaluation
- ✓ Other applicable Notes and Reports

BIDMC Transplant Institute
Lowry Building, 7th floor
110 Francis Street
Boston, MA 02215
Phone: (617) 632-9700 | Fax: (617) 632-9820