SSM Health Cardinal Glennon Children's Hospital

SOLID ORGAN TRANSPLANTATION REFERRAL FORM

Transplant Office Phone: 314-577-5351 Fax: 314-268-4151

Date ______________________ Referring Physician ______________________

Referring Physician phone ______________________ Fax ______________________

Patient name ______________________ DOB ______________________

Guardian's name ______________________ Relationship ______________________

Phone number

Home ______________________ Cell ______________________

Work ______________________

☐ **Check here if referral is internal**

Type of application: ☐ Kidney ☐ Liver ☐ Liver/Kidney ☐ Heart

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Diagnosis ______________________

Comments/Additional information ______________________

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Services Requested

☐ Transplant consultation ☐ Transfer of care ☐ Surgery consultation

☐ Request for dual list for transplant ☐ Second opinion ☐ Other

URGENCY ☐ Urgent (as soon as possible) ☐ Semi-urgent (within two weeks) ☐ Non-urgent (within four weeks)

Primary insurance ______________________

Secondary insurance ______________________

Please forward a copy of the patient's face sheet with insurance information, and if available, copies of pertinent labs, physician notes, imaging reports along with images and biopsy reports.

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