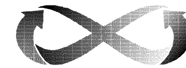
METHODIST SPECIALTY AND TRANSPLANT HOSPITAL

A member of the Methodist Healthcare System

www.SAHealth.com

A Methodist Hospital facility



TEXAS TRANSPLANT INSTITUTE

A member of Methodist Healthcare

San Antonio, Texas

www.TexasTransplant.org

Patient Referral Form

Referral Date: ____________

Diagnosis Information

Previous Transplant? ☐ Yes ☐ No Urgent Referral (explain): ____________

Referral Type: ☐ New ☐ Re-Eval ☐ Listed Inpatient-Where? ____________

Referral for: ☐ Kidney ☐ Liver ☐ Pancreas ☐ Heart

Clinic Location: ☐ San Antonio ☐ Valley ☐ Corpus Christi ☐ Waco

Primary Disease (specific diagnosis required): ____________

Patient Information

Last Name: ____________ First Name: ____________ Middle Initial: ____________

Social Security No.: ____________ Date of Birth: / / Sex: M F

Address: ____________ City: ____________ State: ____________

Zip Code: ____________ Phone: ( ) ____________ Alternate Phone: ____________

-Kidney Patients Only-

Full Name of Dialysis Unit: ____________ Phone ( ) ____________

Initial Dialysis Date: ____________ Fax ( ) ____________

Dialysis Modality: ☐ None ☐ CAPD ☐ CCPD

HD: ☐ M-W-F ☐ T-Th-S

Referring Physician Information

Name: ____________ Phone: ( ) ____________ Fax: ( ) ____________

PCP (if applicable): ____________ Phone: ( ) ____________ Fax: ( ) ____________

Referral Made By: ____________ Title: ____________ Phone: ( ) ____________

Insurance 1: ____________ Subscriber ID: ____________ Group No.: ____________ Cust. Service No.: ____________

Insurance 2: ____________ Subscriber ID: ____________ Group No.: ____________ Cust. Service No.: ____________

Comments: ____________

****FRONT AND BACK COPIES OF ALL INSURANCE CARDS****
INCLUDING TKH & MEDICARE INELIGIBILITY DOCUMENTATION

SO THAT WE MAY SERVE YOU BETTER, A RESPONSE IN ALL FIELDS OF THE REFERRAL FORM ARE REQUIRED.

PHONE: (210) 575-8400 / (800) 888-0402 **FAX: (210) 575-8004**

For Official Use Only

APPT: ____________ **VELOS:** ____________

CONFD W/ PT: ____________ **FINANCIAL:** ____________

PACKET SENT: ____________ **REQUEST MED RECS:** ____________