Dartmouth-Hitchcock MEDICAL CENTER

Phone: (603) 653-3931
Fax: (603) 650-0924

Evaluation Request

Solid Organ Transplantation

Thank you for submitting a Transplant evaluation request for your patient.
Please fax a copy of your patient's most recent labs and office notes with this completed form.
We will contact your patient with an invitation to one of our Transplant classes.

Please check one:

❑ Kidney ❑ Pancreas only ❑ Kidney / Pancreas

Referring provider: ______________________ Date: ____________

Practice Name: ______________________ Office #: ____________

Contact person: ______________________ Fax #: ____________

Patient: Last name: ______________________ First name: ____________

DOB: ______________________ SSN: ____________

Home phone: ____________ Work phone: ____________ Cell phone: ____________

Mailing address: ______________________

Primary care provider: ______________________
(If different than referring provider listed above)

Practice Name: ______________________ Office #: ____________

Contact person: ______________________ Fax #: ____________

Dialysis information:

Unit name: ______________________ Dialysis type: ____________

Telephone #: ______________________ Schedule: ____________

Primary Insurance information:

Company name: ______________________ ID #: ____________

Group #: ______________________ Telephone: ____________

Secondary Insurance information:

Company name: ______________________ ID #: ____________

Group #: ______________________ Telephone: ____________

To be completed by DHMC Transplant Secretary only:

Received date: ______________________ Financial clearance: ____________

Initial evaluation date: ______________________