Beth Israel Lahey Health
Lahey Hospital & Medical Center

DEPARTMENT OF TRANSPLANTATION: KIDNEY

LC#:
Date Referral Came In: **Appointment Given:**

Patient Name: **Intake Staff:**

Date of Birth: **Age:** **Male** **Female** **Social Security #**

Address: **Apt:** **City, State:** **Zip Code:**

Marital Status: **Single** **Married** **Separated** **Widowed** **Divorced**

Home # **Cell #** **Work #**

Email:

Next of Kin & Phone Number:

Interpreter? **No** **Yes** **Language**

Medical Insurance
1)

2)
What is your office visit copay?

PCP: **PCP the referring MD? Yes No**

Address:

Phone #: Fax #:

Nephrologist: **Nephrologist the referring MD? Yes No**

Address:

Phone #: Fax #:

Referring MD: **Referring MD Phone #:**

Ref MD Address: **Fax #:**

On Dialysis Yes No **Hemodialysis** **Peritoneal Dialysis** **Home Dialysis**

Dialysis Days: MWF TThS Other **Dialysis Time Slot:**
Dialysis Center: **Dialysis Phone #:**
Address: **Dialysis Fax #:**
Date of 1st Dialysis: ***(Ask to fax copy of 2728 to Lahey)***
Previous Transplant: Yes No When: **Where:**
Cause(s) of Renal Failure: **Source of information:**