STANFORD
UNIVERSITY
MEDICAL CENTER
Stanford Hospital and Clinics
Lucile Packard Children's Hospital

Evaluation Consultation/Referral Request Form
Adult Kidney and Kidney/Pancreas Transplant Program
750 Welch Road, Suite 200, Palo Alto, CA 94304
Phone: (650)725-9891 Fax: (650) 723-3997
(WEB FORM)

Please indicate the location that you would like your patient to be seen at:
☐ **Stanford main campus**

Or one of the outreach locations:
☐ **Los Gatos** ☐ **Monterey** ☐ **San Francisco** ☐ **Concord**

Date: _____

Patient Name: _____

D.O.B: _____

Address: _____

_____

Phone Number: _____

Name of Insurance: _____
(Please attach a copy of medical insurance card with this referral)

Consultation/Referral Requested by (Print physician name): _____

Physician Signature: _____

Dialysis Unit: _____

Dialysis Schedule: MWF / TThS / **Other:** _____ **Time:** _____

Patient's Preferred Language: _____

Please fax this referral form and a copy of the patient's medical records including most recent H&P, discharge summary, laboratory results, chest x-ray, EKG, cardiac studies, kidney biopsy, recent Pap smear, mammogram, and Immunization records to Stanford Kidney Transplant Office (650) 723-3997. Once the patient is scheduled for Teaching and Evaluation appointments, a confirmation letter will be sent to the patient, nephrologist, and dialysis unit. Thank you.