**Date:**_____

# Transplant Referral Form

## PATIENT INFORMATION:

Patient Name: _____
Address: _____
City, State, Zip: _____
Cell Phone: _____
Home Phone: _____Language:_____
Date of Birth: _____ Gender: ☐ Male ☐ Female
Guardian/Caregiver & Number: _____

## PRESCRIBER INFORMATION:

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA:_____ NPI: _____
Office Contact: _____

## INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card if available)

Insurance Name: _____ID Number: _____ Group: _____

## CLINICAL INFORMATION

**DIAGNOSIS: ICD-10** _____

Date of Transplant: _____

**TYPE:** ☐ Heart ☐ Lung ☐ Pancreas ☐ Kidney ☐ Liver

**MEDICAL CONDITIONS:**

☐ Hypertension ☐ Diabetes ☐ ESRD

Other:_____

Weight (kg): _____ Height (cm) _____ **Therapy** ☐ New ☐ Reauthorization ☐ Restart

SCr/CrCl _____ WNL: ☐ Yes ☐ No LFTs _____WNL: ☐ Yes ☐ No

☐ Dialysis (type): _____ Schedule: _____

Blood Type: _____**Prior Therapies:** _____

Tx Response/Dates: _____

Allergies: _____

| Medication | Dose/Strength | Directions | Quantity | Refills |
|---|---|---|---|---|
| ☐ **Astagraf XL** (Tacrolimus) | ☐ 0.5mg ☐ 1mg ☐ 5mg | | | |
| ☐ **Azasan** (Azathioprine) | ☐ 75mg ☐ 100mg | | | |
| ☐ **Cellcept** (Mycophenolic mofetil) | ☐ 250mg ☐ 500mg ☐ 200mg/ml | | | |
| ☐ **Envarsus XR** (Tacrolimus) | ☐ 0.75mg ☐ 1mg ☐ 4mg | | | |
| ☐ **Gengraf** (Cyclosporine modified) | ☐ 25mg ☐ 100mg ☐ 100mg/ml | | | |
| ☐ **Imuran** (Azathioprine) | ☐ 50mg | | | |
| ☐ **Myfortic** (Mycophenolic acid) | ☐ 180mg ☐ 360mg | | | |
| ☐ **Neoral** (Cyclosporine modified) | ☐ 25mg ☐ 100mg ☐ 100mg/ml | | | |
| ☐ **Prograf** (Tacrolimus) | ☐ 0.5mg ☐ 1mg ☐ 5mg | | | |
| ☐ **Rapamune** (Sirolimus) | ☐ 0.5mg ☐ 1mg ☐ 2mg ☐ 1mg/ml | | | |
| ☐ **Sandimmune** (Cyclosporine non-modified) | ☐ 25mg ☐ 100mg ☐ 100mg/ml | | | |
| ☐ **Zortress** (Everolimus) | ☐ 0.25mg ☐ 0.50mg ☐ 0.75mg | | | |
| ☐ **Bactrim** (SMZ/TMP) | ☐ 800/160mg (DS) ☐ 400/80mg (SS) | | | |
| ☐ **Clotrimazole** | ☐ 10mg Troches | | | |
| ☐ **Furosmide** | ☐ 20mg ☐ 40mg | | | |
| ☐ **Lidocaine 5% Patch** | ☐ 700mg/patch 5% | | | |
| ☐ **Prednisone** | | | | |
| ☐ **Protonix** (Pantoprazole) | ☐ 20mg ☐ 40mg | | | |
| ☐ **Valcyte** (Valganciclovir) | ☐ 450mg ☐ 50mg/ml | | | |
| ☐ **Vfend** (Voriconazole) | ☐ 50mg ☐ 200mg ☐ 40mg/ml | | | |
| ☐ **Other:** | | | | |
| ☐ **Other:** | | | | |

☐ **Equipment**: _____ ☐ Transplant Kit (BP Monitor & Cuff, Thermometer, Pill Cutter & Box) Cuff Size: _____☐ Scale

**Prescriber Signature: Stamp signature not allowed, physician signature required** Verbal Readback ☐ Yes ☐ No

X_____ X_____ Date: _____

Dispense as written Product substitution permitted