UTERUS TRANSPLANT REFERRAL FORM

PATIENT DEMOGRAPHIC INFORMATION

Date: _____

Patient Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Social Security Number: _____ Date of Birth: _____ Gender: M F Race: _____

Home Phone: _____ Mobile Phone: _____

REFERRING PHYSICIAN INFORMATION AND SPECIALTY (IF APPLICABLE):

Name: _____

Specialty: _____

Address: _____

City: _____ State: _____ ZIP: _____

Office Phone: _____ Fax: _____

PATIENT INSURANCE INFORMATION (PLEASE ATTACH A COPY OF BOTH SIDES OF INSURANCE CARD):

Insurance Company Name: _____ Policyholder's Name: _____

Policyholder's Date of Birth: _____ Insurance Company Phone: _____

Policy Number: _____ Group Number: _____

MEDICAL INFORMATION/DOCUMENTATION (PLEASE SEND ALL THAT ARE AVAILABLE):

- Op reports related to diagnosis
- Gynecological procedures
- Gynecological notes
- Immunization record
- REI records
- PCP records
- Radiology reports
- U/S renal
- CT abdomen and pelvis
- MRI abdomen and pelvis
- Labs:
  - CBC
  - BMP/CMP
  - Coagulation
  - HIV
  - Syphilis
  - HBV, HCV
  - CMV
  - Blood typing

PLEASE FAX COMPLETED FORM WITH DOCUMENTATION TO THE UTERINE TRANSPLANT OFFICE AT 205.996.9734 or email uterustransplant@uabmc.edu.