

**HEALTH NET  
TRANSPLANTATION REQUEST  
KIDNEY**

Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Member #: \_\_\_\_\_

Transplant Type: \_\_\_\_\_

Etiology of Organ Failure: \_\_\_\_\_

Attending Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Form Completed By: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

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**ATTENDING PHYSICIAN ATTESTATION**

The responses in this document have been reviewed and are accurate.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

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PATIENT CLINICAL PROFILE

CLINICAL HISTORY

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DOCUMENTATION OF END-STAGE KIDNEY DISEASE

Treatment during the past 24 months (date of initial dialysis, if applicable)

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Present Treatment

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Kidney biopsy result \_\_\_\_\_

Kidney function tests

Result

BUN	_____
Creat	_____
Na+	_____
K+	_____
Cl-	_____
HCO3-	_____

Abdominal ultrasound result \_\_\_\_\_

CAT scan result \_\_\_\_\_

Arteriogram result \_\_\_\_\_

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Thallium treadmill result \_\_\_\_\_

Cardiac cath result \_\_\_\_\_

**OTHER MEDICAL FACTORS**

Does the patient have?

	<b><u>YES</u></b>	<b><u>NO</u></b>	<b><u>DOCUMENTATION</u></b>
Cardiac Dysfunction	_____	_____	_____
Liver Dysfunction	_____	_____	_____
Pulmonary Dysfunction	_____	_____	_____
Active Infection	_____	_____	_____
Peripheral Vascular Disease	_____	_____	_____
Cerebrovascular Disease	_____	_____	_____
Diabetes	_____	_____	_____
Prior History of Malignancy	_____	_____	_____
Active Peptic Ulcer Disease	_____	_____	_____

**LAB TESTS**

Hepatitis B

Antigen      Positive: \_\_\_\_\_      Negative: \_\_\_\_\_

Antibody      Positive: \_\_\_\_\_      Negative: \_\_\_\_\_

HIV      Positive \_\_\_\_\_      Negative: \_\_\_\_\_

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Psychosocial background, including history of alcohol or drug abuse:

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Other Comments:

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