UI Health | UIC

TRANSPLANT REGISTRATION FORM

Liver ✔ Kidney Pancreas Small Bowel

Please Print Legibly - Completed by: Information given by:

***(For Kidney Only) Did the patient have a previous transplant? ☐ Yes ☐ No

***If yes, which organ type

***Name and Phone Number of Transplant Center

Date: **Nurse Coordinator:**

Patient Name: MRN:

DOB: Sex : Race: SSN#

Address: City: State: Zip:

Patient Phone: Cell:

Email Address:

LIVING DONOR NO YES If YES, you can bring the donor with you to the appointment. Please have them call 312-996-6771 to register.

INSURANCE COVERAGE

Medicare #: Part A Effective Date: Part B Effective Date:

Third Party Coverage: ☐ HMO ☐ PPO ☐ POS ☐ OTHER

Name of Carrier: Policy Holder:

Relationship: Policy Holder SSN:

Group Name: Group #: Policy #:

Insurance Co. Phone #:

Medicaid RIN#: Case ID#:

	Guarantor	Health Plan	Pre Tx Eval	Event	Post Tx
Recipient				Recipient's Insurance	Recipient's Insurance
Donor				ACC	ACC

(section above must be completed by financial counselor only) Financial Counselor Signature: _____

MEDICAL

Have you had the Covid vaccine? ☐ NO ☐ YES If yes, list dates:

Dialysis Center: Phone:

Address: City: State: Zip:

Specialist (Hepatologist, Nephrologist): Phone:

Address: City: State: Zip:

Referral From: PCP Specialist Self Other

Contact Person at Dialysis Center:

Diagnosis: Date of 1st Dialysis:

Sun Mon Tues Weds Thurs Fri Sat

Please send complete form and copy of patient's insurance card (front and back) to:

Transplant Assistants -Transplant Center
University of Illinois Hospital & Health Sciences System
1855 W. Taylor Street, Suite 1077, MC 950
Chicago, IL 60612-7315
Tel 312-996-6771, Fax 312-413-3483

**If patient is on dialysis, please cc: the registration form to Olivia Fox at ofox@uic.edu.