Hartford HealthCare
Hartford Hospital

Transplant Program Referral Form

Please note the following:

- This form is to be completed by a referring physician, patient, or a person the patient has authorized to complete this form. *Please do not complete this form if you do not have the patient's consent.*
- This form is not designed to respond to medical emergencies. If you are currently experiencing a medical emergency, please contact your current health care provider, dial 911 or go to your nearest emergency room.
- A representative from the Transplant Program will contact you within one business day.

(= Required)*

* Referral is being completed by: ☐ Patient/Designee ☐ Referring Physician

* Reason for Referral: ☐ Kidney Evaluation ☐ Liver Evaluation ☐ Heart Evaluation

Patient Information:

* Patient Name:

* Date of Birth:

Address:
Street 1
Street 2
City
State Zip
Country

Work Phone: Best time to call:
May we leave a message? ☐Y ☐N

Home Phone: Best time to call:
May we leave a message? ☐Y ☐N

Cell Phone: Best time to call:
May we leave a message? ☐Y ☐N

* Email Address:

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Referring Physician Information *(if applicable)*:

Physician Name:

Practice Name:

Address:

Street 1

Street 2

City

State Zip Country

Practice Phone:

Practice Fax:

Practice Email Address:

Other Information:

* Preferred Means of Communication (select one):

Contact the *Patient*:	Contact the *Practice*:
☐ Work Phone	☐ Phone
☐ Home Phone	☐ Email
☐ Cell Phone	☐ Fax
☐ Email	

Patient condition/other comments:

Form may be mailed to:
Transplant Program
Hartford Hospital
85 Seymour Street
P.O. Box 5037
Hartford, CT 06106

Or faxed to:
860-545-4366