FAMILY HOUSE
Mid·America Transplant

Referral Form

Patient Information

Patient Name:		
Date of Birth:	SSN:	Phone:
Patient Age:	Patient Sex:	Patient Race:
Patient Status: ☐ Pre-Transplant ☐ Post-Transplant		Patient to Stay at Family House ☐ Y ☐ N
Requested Check-In Date:	Anticipated Length of Stay:	
Referring Transplant Center:		
Name of Transplant Center Representative:	Phone:	Email:
☐ Kidney ☐ Liver ☐ Heart ☐ Lung ☐ Pancreas	Special Needs:	

Responsible Party Primary Contact Information

Name (if different from patient)		
Address:		
City:	State:	ZIP Code:
Primary Phone:	Email:	Relationship to Patient:
☐ Own ☐ Rent	Monthly Payment or Rent:	How Long?
Employer:	Position:	Family Annual Income:
Number of Guests in Apartment:		
Does the Guest have their own transportation?		

Payment Information

Who is responsible for rent payment? (Check One)

☐ Family Self-Pay	☐ Family Applying for Financial Assistance from Mid-America Transplant: Please see Financial Assistance Application (Page 2)
☐ Family Receiving Assistance from _____	

Signature of Transplant Center Representative:	Date:
Signature of Responsible Party:	Date:

Mid-America Transplant Family House
Fax: 314.735.8494 Phone: 314.357.6261