

## Pre-Waitlist Transplant Referral Form Instructions

### OPTN Patient Identification

**Transplant Center:** The transplant center information displays. Verify that the center information is the hospital where the patient was referred.

**Transplant Center Code:** The transplant center information displays. Verify that the center information is the hospital where the patient was referred.

**Patient MRN:** Patient's Medical Record Number (MRN) assigned by the Transplant Center. Enter the patient's Medical Record Number at the Transplant Center. This is a **required** field.

**Organ:** Select the organ the patient was referred for transplant evaluation at your program. This is a **required** field.

Must select one:

Heart  
Heart-Lung  
Intestine  
Kidney  
Kidney-Pancreas  
Liver  
Lung  
Pancreas  
Pancreas Islets  
VCA - abdominal wall  
VCA - external male genitalia  
VCA - head and neck  
VCA - lower limb  
VCA - musculoskeletal composite graft segment  
VCA - other genitourinary organ  
VCA - spleen  
VCA - upper limb  
VCA - uterus  
VCA - vascularized gland

## Patient Demographics

**First Name:** Enter the patient's first name. This is a **required** field.

**Middle Name:** Enter the patient's middle name. This is a **required** field.

Must either:

Provide value,

Select unknown, or

Select not applicable.

**Last Name:** Enter the patient's last name. This is a **required** field.

**DOB:** Enter the patient's date of birth. This is a **required** field.

**Birth Sex:** Patient's sex at birth. Select the patient's sex (Male or Female), based on biologic and physiologic traits at birth. This is a **required** field.

Must select one:

Female

Male

**SSN:** Enter the patient's social security number. This is a **required** field.

Must either:

Provide value (000-00-0000),

Select unknown, or

Select not applicable.

**Race:** OMB defines race as a person's self-identification with one or more social groups. This is a **required** field.

Must select at least one:

White

European Descent

Arab or Middle Eastern

North African (non-Black)

Other Origin

Origin Not Reported

Black or African American

African American

African (Continental)

West Indian

Haitian

Other Origin

Origin Not Reported

Asian

Asian Indian/Indian Sub-Continent

Chinese

Filipino

Japanese

Korean

Vietnamese

Other Origin

Origin Not Reported

American Indian or Alaska Native

American Indian

Eskimo

Aleutian

Alaska Indian

Other Origin

Origin Not Reported

Native Hawaiian or Other Pacific Islander

Native Hawaiian

Guamanian or Chamorro

Samoan

Other Origin

Origin Not Reported

Race Not Reported

**Ethnicity**: OMB defines ethnicity to be whether or not a person self-identifies as Hispanic or Latino. This is a **required** field.

Must select one:

Hispanic or Latino

Not Hispanic or Latino

Ethnicity not reported

### Contact Information

**Primary Phone Number:** Enter the primary phone number at the time of referral. This is a **required** field.

Must either:

Provide value (000-000-0000),

Select unknown, or

Select not applicable.

**Permanent Street Address:** Enter the street address where the patient permanently resides at the time of referral (location of full-time residence, not where the patient is currently staying for the referral). This is a **required** field.

Must either:

Provide value or

Select unknown.

**City of Permanent Residence:** Enter the city where the patient permanently resides at the time of referral (location of full-time residence, not where the patient is currently staying for the referral). This is a **required** field.

Must either:

Provide value or

Select unknown.

**State of Permanent Residence:** Select the name of the state of the patient's permanent address at the time of referral (location of full-time residence, not where the patient is currently staying for the referral). This is a **required** field.

Must either:

Provide value or

Select unknown.

**Zip Code of Permanent Residence:** Enter the patient's zip code at the time of referral (location of full-time residence, not where the patient is currently staying for the referral). This is a **required** field.

Must either:

Provide value or

Select unknown.

**Country of Permanent Residence**: Enter the country where the patient permanently resides at the time of referral (location of full-time residence, not where the patient is currently staying for the referral). This is a **required** field.

Must either:

Provide value or

Select unknown.

### Financial Resources

**Source of Payment/Primary**: Select the patient's primary source of payment (largest contributor) during the referral period. This is a **required** field.

Must select one:

Private insurance (Commercial Health Insurance)

Public insurance – Medicaid

Public insurance – Medicare FFS (Fee-for-Service)

Public insurance – Medicare Part C or Medicare Advantage

Public insurance – CHIP (Children's Health Insurance Program)

Public insurance – Department of VA

Public insurance – TRICARE

Public insurance – Indian Health Service

Public insurance – State program

Self-pay

Donation

Free Care (Charity Care)

Pending

Foreign Government

**Source of Payment/Secondary**: Select the patient's secondary source of payment during the referral period. This is a **required** field.

Must select one:

TBD

### Referral Details

**Referral Date:** Enter the date when the patient was referred to the transplant program (MM/DD/YYYY). This is a **required** field.

**Referring Provider NPI:** Unique identification number used by health plans to identify providers for billing and claims. Enter the National Provider Identifier (NPI) of the referring provider. This is a **required** field.

Must either:

Provide value (0000000000) or

Select unknown.

**Referral Status:** Select the referral status. This is a **required** field.

Must select one:

Active – The referral is in progress.

Closed – The referral was closed by the transplant program.

**Referral Closure Reason:** Select the closure reason from the dropdown menu. This is a **required** field.

Must select one:

Active/recent malignancy – Closed due to presence of active malignancy or recent (<5 years) high risk malignancy.

Active mental/behavioral health barriers – Closed due to the presence of untreated or uncontrollable mental health or behavioral health conditions or disorders that interfere with an individual's ability to make an informed healthcare decision, provide informed consent, or adhere to the established care plan; may also include ongoing behavior that prohibits the delivery of appropriate and adequate transplant-related care, including but not limited to, unwillingness or inability to work productively with the transplant care team.

Canceled due to error – Canceled by the transplant program due to erroneous submission.

Evaluation started – Patient began testing for evaluation.

Evaluation started – Patient completed the initial visit for evaluation.

Financial/insurance issues – Closed due to insufficient finances or insurance coverage for transplant due to a variety of reasons including, but not limited to, immigration status and/or homelessness.

Inadequate patient caregiver support – Closed due to insufficient social support for transplantation and related care.

Nutritional/metabolic issues – Closed due to the presence of significantly low/high BMI measurements, frailty, cachexia, malnutrition and/or poorly controlled metabolic syndrome.

Patient age – Closed due to risks associated with advanced age.

Patient choice – Patient requested to discontinue the transplant referral or evaluation for any reason. This includes transition to hospice.

Patient died – Patient died during course of transplant referral.

Patient unable to adhere – Closed due to habitual non-attendance to scheduled appointments and/or nonadherence to the treatment plan.

Refusal to accept blood products – Patient refusing to receive blood transfusions due to non-medical reasons.

Refusal to vaccinate – Patient refusing to vaccinate according to present CDC recommendations or programmatic policy for non-medical reasons.

Substance use/abuse – Closed due to reported consumption/misuse of substances either on individual occasions or as a regular practice.

Surgical complexity – Closed due to the presence of significant anatomical issues.

Too well for transplant – Patient's illness is not severe enough for transplant surgery. Transplant program advised the patient to pursue chronic disease management services to prevent progression into end-stage organ failure.

Too sick for transplant – Patient's illness is too severe to undergo transplant surgery (e.g., too unstable, on multiple life support systems, or in a coma with evidence of irreversible brain injury).

Transferred to another center – Patient was transferred to another transplant center.

Transplanted at another center – Patient was transplanted at another transplant center.

Unable to contact patient – Unable to contact the patient due to incomplete or inaccurate information.

**Referral Closure Date:** Required if Referral Status is Closed, Enter the referral closure date (MM/DD/YYYY).

**Death Date:** Enter the actual or estimated patient date of death (MM/DD/YYYY). This is a **required** field.

**Public Burden Statement:** The private, non-profit Organ Procurement and Transplantation Network (OPTN) collects this information in order to perform the following OPTN functions: to assess whether applicants meet OPTN Bylaw requirements for membership in the OPTN; and to monitor compliance of member organizations with OPTN Obligations. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0906-XXXX and it is valid until XX/XX/202X. This information collection is required to obtain or retain a benefit per 42 CFR §121.11(b) (2). All data collected will be subject to Privacy Act protection (Privacy Act System of Records #09-15-0055). Data collected by the private non-profit OPTN also are well protected by a number of the Contractor's security features. The Contractor's security system meets or exceeds the requirements as prescribed by OMB Circular A-130, Appendix III, Security of Federal Automated Information Systems, and the Departments Automated Information Systems Security Program Handbook. The public reporting burden for this collection of information is estimated to average 0.35 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Information Collection Clearance Officer, 5600 Fishers Lane, Room 14NWH04, Rockville, Maryland, 20857 or [paperwork@hrsa.gov](mailto:paperwork@hrsa.gov).