## RENAL/PANCREAS TRANSPLANT REVIEW AND REFERRAL FORM

### General Information

Please find enclosed UNC Hospitals' Transplant Review and Referral Form for the renal/ pancreas transplant program. This form will streamline the process of referral for you, as well as give us important information with which to start evaluation for your patient.

We ask that you use both parts of this form when you are requesting a transplant evaluation, unless you have indicated that a patient is clearly not a transplant candidate at this time. In this case, you do not need to complete Part II. In either event, a copy of our transplant surgeon's opinion will be returned to you in order to comply with yearly review regulations. All review forms should be submitted to:

UNC Center for Transplant Care
Kidney Transplant Program
101 Manning Dr. RM 4056
Chapel Hill, NC 27514
FAX: 984-974-0888
Phone: 984-974-9950

When Parts I and II are received, we will contact the patient and explain the process of scheduling an initial appointment for our transplant orientation class. Part I will be returned to the referring nephrologist. The patient will be sent a letter with information about times and dates of upcoming orientation classes and a copy will be sent to you.

In addition to receiving written information, patients attending the transplant orientation class will attain a general overview of the evaluation process, risks and benefits of renal transplant for treatment of ESRD, and deceased versus live donor issues. After attending orientation class and receiving insurance authorization, the patient can proceed with the medical evaluation. Initial appointments (i.e. labs, chest x-ray, EKG, Nephrology, Cardiology, etc.) will be scheduled for the patient. Patients will be notified of all appointments by letter.

For select patients, the orientation class may be omitted (those who are non-English speakers, hearing impaired or with exceptional medical considerations). These patients will receive transplant education individually with their nurse coordinator and the transplant team.

During successive trips to the hospital, and unless contraindicated, we will always try to schedule as many appointments as feasible so that the patient can complete his/her evaluation in a timely manner.

We hope this will be helpful to everyone involved in the transplant process, and we thank you for suggestions and your continuing interest.

# UNC Center for Transplant Care
# Renal/Pancreas Transplant Review and Referral Form
# Part I

*Name: _____*Social Security #: _____

*Address: _____*City:_____*State:_____

*Zip Code: _____*County: _____Phone (H): _____Phone (Cell):_____

*Date of Birth:_____Sex: _____ *Race _____ *Height:_____*Weight:_____

*Patient's EMAIL (if applicable)_____

***Cause of ESRD**: _____Diabetes: _____Yes _____No

Referral for combined Kidney/Pancreas transplant? _____Yes _____No

*****Current Modality: _____CAPD _____CCPD _____ICHD _____Home Hemo _____None

Dialysis Days: _____M-W-F _____T-T-S _____AM _____PM

Does patient have transportation? _____ What form of transportation? (personal vehicle, county van, etc.)_____

Date of 1st Dialysis:_____Current Dialysis Center:_____

Dialysis Phone number_____ Fax number_____

Has patient ever been seen at UNC Hospitals? _____Yes _____No _____Unknown

UNC Medical Record Number: _____

**Type of Insurance: Medicaid____ Medicare ____ BCBS ____ Other_____None_____**

H/O Malignancy _____Yes _____No
Suspected Substance Abuse _____Yes _____No
Is patient compliant with dialysis? ____Yes ____No
Is patient compliant with meds? ____Yes ____No
Active HIV: _____Yes _____No
**If HIV(+) please send current Viral Load and CD4 count (viral load must be undetectable, CD4 ct must be >200)**
Patient declines transplant: _____Yes _____No
Previous Transplant _____Yes _____ No
Patient has received transplant education information locally: _____Yes _____No

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*****Referring Nephrologist's Assessment as to Transplant Candidacy/Opinion:

I feel this patient is an: _____Acceptable Referral **OR** _____Unacceptable Referral for Transplant Evaluation

_____Cardiovascular status precludes transplant _____Pulmonary status precludes transplant
_____Level of understanding and compliance precludes transplant _____Recurrent infections preclude transplant

Note other medical problems that may preclude or place patient at an increased risk for transplant:

_____

_____ I do not anticipate this patient will be a candidate for transplant now or in the future due to:

_____

_____/_____Date:_____
Signature of referring Nephrologist Print Name

*** Indicates these must be completed**

# UNC Center for Transplant Care
# Renal/Pancreas Transplant Review and Referral Form
# Part I

Pt's name:_____

**Transplant Surgeon's Opinion:**

I _____Agree_____Disagree with the referring nephrologist's opinion

I feel this patient is an:_____Acceptable _____Unacceptable _____Marginal Transplant Referral

I_____Agree_____Disagree that this patient should not be considered for renal transplant now or in the future.

_____ Date:_____
Signature of Transplant Surgeon

**Referral Received:**

_____Patient will be contacted by UNC Center for Transplant to schedule Renal Transplant Orientation Class.

_____Additional information is required from referring doctor/dialysis center.

_____

_____

_____Patient previously referred/evaluated. Outcome as follows:

_____

_____

_____

_____

_____Patient not a candidate due to:

_____

_____

_____ Other:

_____

_____

# UNC Center for Transplant Care
# Renal/Pancreas Transplant Review and Referral Form
# Part II

## Transplant Referral Information Check Sheet

(This information should be provided with the referral unless indicated that this patient is not a transplant candidate)

**PLEASE NOTE THAT THE FOLLOWING REFERRAL INFORMATION IS REQUIRED TO INITIATE AND EXPEDITE THE TRANSPLANTATION PROCESS**

_____ Completed UNC Hospitals Transplant Review and Referral Form

_____ Recent (within the past 6 months) history and physical, or the referring physician's initial note, which includes a comprehensive history and physical

_____ Most recent hospital discharge summary

_____ Most recent EKG and Laboratory values (blood work, UA, C & S if possible)

_____ Results of any consultations obtained within the past 12 to 18 months. For example, cardiac consult to rule out MI; GI consult to evaluate guiac (+) emesis or any problems that have required additional follow up through support services

_____ Social Work Assessment

_____ Dietary Assessment

_____ Face sheet of demographics

_____ Copy of insurance cards

_____ 2728 form (if on dialysis)

_____ Documentation of GFR 0f 20.0 or less (if not on dialysis)

_____ PPD results

_____ Any additional information you feel would expedite the care of your patient in the evaluation process

***** We would appreciate one-side only copies******
**Thank you!**