KIDNEY/PANCREAS TRANSPLANT REVIEW AND REFERRAL FORM

General Information

Please find enclosed UNC Hospitals’ Transplant Review and Referral Form for the kidney/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.
Chapel Hill, NC 27514
FAX: 984-974-0888        Phone: 844-862-5436 (844-UNC-KIDN)

When Parts I and II are received and reviewed by our Intake Coordinator, insurance details are forwarded to our Transplant Financial Coordinators, who verify the insurance information and obtain authorization. In the meantime, the Intake Coordinator contacts the patient to make sure the address and phone numbers are correct, and to talk with the patient about what to expect during the evaluation process. The people who do the scheduling are notified when insurance authorization is obtained, and they call the patient to schedule several appointments. We refer to these as a “bundle.” The bundle includes our transplant information class, an appointment with the transplant nephrologist, a meeting with the financial coordinator to clarify benefits, and a meeting with the social worker. We ask each patient to bring a support person who will be able to help after transplant, and the social worker will be talking with him or her as well. Both you and the patient will receive a copy of the letter with appointment date and times.

In addition to receiving written information, patients attending the transplant orientation class will get a general overview of the evaluation process, hear about risks and benefits of kidney transplant, and will be given information about living donors.

Our nephrologist will talk with the patient about what other appointments will be needed in order to complete the evaluation. Patients are asked to arrange some appointments

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locally, including dental, mammogram, and colonoscopy, with copies of the reports to be faxed to us. Those appointments can also be scheduled by our team at UNC if the patient prefers. For any appointment here, a letter will be sent to the patient; you’ll receive a copy, too. 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
Kidney/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

Does the patient have a primary care provider? _____ PCP’s Name:_____________________________

*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

_________________________________________________________________________________________________

*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

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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 kidney transplant now or in the future.
__________________________________________ Date: ________________
Signature of Transplant Surgeon

Referral Received:
_____Pt will be contacted to schedule appointments after insurance verification.
_____Additional information is required from referring doctor/dialysis center.
__________________________________________________________________________________________
__________________________________________________________________________________________
_____Patient previously referred/evaluated. Outcome as follows:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
_____Patient not a candidate due to:
__________________________________________________________________________________________
__________________________________________________________________________________________
_____Other:
__________________________________________________________________________________________
__________________________________________________________________________________________
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Kidney/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
- Demographics Face Sheet (please be sure address and phone numbers are current)
- Copy of insurance cards
- 2728 form (if on dialysis)
- Documentation of GFR of 20.0 or less (if not on dialysis)
- PPD results, less than 12 months old
- 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!