MUSC Health
TRANSPLANT CENTER

ASCREENCRIT

Referral for Kidney / Pancreas Transplantation

Form Origination Date: 7/2013
Version: 6 Version Date:12/2021

PATIENT NAME ______________________________

MRN______________________________________

PATIENT IDENTIFICATION LABEL

DOB: __________________________ Age: ______________ Gender:______

Address:____ County:_____________ Zip: _________

Best contact number #:__________________________ Social Security number #:____________________________

Ht. (cm): ____________ Wt. (kg): ___________ BMI:__________

Ethnicity: ☐ White ☐ Black/African American ☐ American Indian/Alaska Native
☐ Hispanic/Latino ☐ Hawaiian/Pacific Islander ☐ Asian ☐ Other: _________

Diagnosis:____ HD days: MWF/TTS

Date of Dialysis Onset: _____________ Dialysis Unit: _____________________ Best contact: _________________

☐HD ☐ Peritoneal Address: ____

Diabetes? ☐ Yes ☐ No **Date/Age of Onset**: _______________

Has your patient ever had:

Heart attack, stroke, stent in the heart, or bypass?	☐ Yes ☐ No
Previous transplant?	☐ Yes ☐ No
Malignancy other than skin or renal in the past 2 years?	☐ Yes ☐ No
Active immunological disease (Wegener's, Lupus, Good pasture)?	☐ Yes ☐ No
Sickle Cell Disease?	☐ Yes ☐ No
Severe Osteoporosis?	☐ Yes ☐ No
Active alcohol or substance abuse?	☐ Yes ☐ No
Neurological impairment?	☐ Yes ☐ No
HIV?	☐ Yes ☐ No
Significant history of non compliance with medical treatment?	☐ Yes ☐ No

Comments from **Nephrologist** concerning patient's candidacy for renal transplantation:

____

Referral to ☐ Lancaster and Charleston Programs ☐ Charleston ☐ Lancaster

Is your patient? ☐ Wheelchair Bound ☐ Cannot walk ½ block ☐ Cannot climb ½ flight of stairs ☐ Oxygen dependent

Patient is an ☐ Excellent ☐ Good or ☐ Marginal candidate for transplantation

Referral should include:
- ☐ Clinical Documentation (Most current H&P, labs and/or Discharge Summary)
- ☐ Copy of insurance cards (front & back)
- ☐ For HIV patient: Infectious Disease MD:___________________________________
- ☐ Copy of CMS Form 2728

Complete and return form by Fax to: 843-876-2968

Nephrologist Signature: ____

Nephrologist Printed Name: ____