PRINT PRINT COMPLETED FORM & RESET RESET

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: _____