

Referral for Pancreas Transplantation

PLEASE FILL OUT COMPLETELY - Return to:

Medical University of South Carolina
Renal / Pancreas Transplant Program
162 Ashley Avenue
PO Box 250586
Charleston, S.C 29425
Phone: 843-792-4177; Fax: 843-876-2968

Date of Referral: _____ Contact: _____

PATIENT NAME: _____ Age: _____ Race: _____ Sex: _____

Address: _____ Ht(cm): _____ Wt(kg): _____

_____ Phone #: _____

SS#: _____ DOB: _____

Medicare #: _____ Medicaid #: _____

Other Insurance: _____

Endocrinologist: _____

Address: _____ Phone: _____

Other Health Care Provider: _____

Phone: _____ 24 Hour #: _____

Diagnosis: _____

Age of Diabetes Diagnosis: _____ Insulin Dose: _____

C-Peptide: _____ 24 Hr Urine: Cr Cl _____

Total Protein: _____

List of Any Diabetic Complications: _____

ABO: _____ Hypertension?: _____ Allergies: _____

Meds: _____

Prior Transplant? _____ When? _____

Transfusion history w/ dates: _____

Pregnancies ? : _____ PPD: _____

Statement by **Endocrinologist** concerning patient's candidacy for pancreas transplantation:

Excellent Good Marginal

Endocrinologist Signature

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Referral must include:

- History & Physical and/or discharge summaries**
- Most recent labs; including a 24 hour urine for creatinine clearance and total protein**
- Completed referral form**
- Copy of all insurance cards (front & back)**
- Current PPD**
- Cardiology evaluation for positive history**
- GI: Colonoscopy for positive history or age \geq 50**
- Women: PAP smear age \geq 18; Mammogram for age \geq 40 or positive history**
- Men : Current PSA \geq age 50**

- Please attach reports of any of the following studies if available:**
- Chest X-Ray**
- EKG**

As much testing that can be completed at home will only expedite the referral process.

Revised: 01/31/05