

Who, What, When, Where

Pancreas Referrals

WHO?

Type1 diabetics with ESRD

WHAT?

Simultaneous Kidney/Pancreas
Transplant

WHEN?

NOW!!! Do not have to wait until patient
starts dialysis ($\text{CrCl} \leq 30\text{cc/min}$)

WHO?

Type 1 diabetic with no renal
dysfunction

WHAT?

Pancreas Transplant

WHEN?

NOW!!!

INDICATIONS:

Type 1 Diabetics that experience any of the following complications:

- Hyperlabile blood sugars
- Asymptomatic hypoglycemia
- Documented episodes of DKA
- Multiple secondary complications
 - Retinopathy
 - Gastroparesis
 - Neuropathy
 - Accelerated atherosclerosis
- Failure of intensive medical intervention

ABSOLUTE CONTRAINDICATIONS:

- Malignancy w/in past two years (other than skin)
- Cardiovascular or pulmonary disease sufficiently severe to prevent surgery
- HIV+
- Active Infection
- BMI>30
- Active alcohol or substance abuse

Relative Contraindications for SPK Transplant and PTA :

- Severe peripheral vascular disease
- Advanced age > 54
- Emotional and psychiatric instability
- Probable inability to understand or comply with necessary treatment after transplantation
- Insufficient support/Noncompliance with medical regime

WHERE:

MUSC

TRANSPLANT CENTER

OUR GOAL....



The Process

Step 1: The Referral

Step 2: Transplant Education Class

Step 3: The Medical Evaluation

Step 4: Selection Committee

Step 5: THE LIST

Ongoing.....

Monthly updates/reports

Yearly data collection

Referral Forms

Referral for Pancreas Transplantation

PLEASE FILL OUT COMPLETELY - Return to:

Medical University of South Carolina
Renal / Pancreas Transplant Program
160 Rutledge 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

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

Referral Forms

Referral for Renal/Pancreas Transplantation

PLEASE FILL OUT COMPLETELY - Return to: Medical University of South Carolina
 Renal/Pancreas Transplant
 160 Rutledge Avenue
 PO Box 250586
 Charleston, S.C 29425
 Phone: 843-792-4177; Fax: 843-876-2968

Date of Referral: _____ Form Complete By: _____

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

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

Phone #: _____

SS#: _____ DOB: _____

Medicare #: _____ Medicaid #: _____

Other Insurance: _____

Dialysis Unit: _____ Dialysis Days: M T W Th F Sat
 Peritoneal

Address: _____ Phone: _____

Date of Dialysis Onset: _____

Nephrologist: _____

Phone: _____ 24 Hour #: _____

Diagnosis: _____ Biopsy: _____

ABO: _____ Hypertension?: _____ Allergies: _____

Meds: _____

Diabetes?: _____ Date/Age of onset: _____ Insulin Dose: _____

Native Nephrectomy?: _____ Reason: _____

Prior Transplant? _____ When? _____

Transfusion history w/dates: _____

Pregnancies?: _____ PPD: _____

Statement by **Nephrologist** concerning patient's candidacy for renal transplantation:

 Excellent Good Marginal Nephrologist Signature

Statement by **Unit Coordinator** concerning patient's candidacy for renal transplantation.

 Excellent Good Marginal Unit Coordinator Signature

Statement by **Social Worker** concerning patient's candidacy for renal transplantation.

 Excellent Good Marginal Unit Social Worker

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Referral must include:

- History & Physical and/or discharge summaries
- Most recent labs
- Social Worker assessment
- Dietary assessment
- Completed referral form
- Copy of all insurance cards (front & back)
- Most recent renal ultra-sound or CT Scan
- Current PPD
- Cardiology evaluation for positive history
- GI: Colonoscopy for positive history or age ≥ 50
- Women: PAP smear for age ≥ 18 ; Mammogram for age ≥ 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 done at home will only expedite the referral process.

Revised: 09/07/06

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