

Pancreas Transplant Alone Referral

BLOODWORK & URINE TESTS (within the last 6 months of referral date & to be repeated yearly)	
<input type="checkbox"/> ABO Blood Group <input type="checkbox"/> HBsAg, HBsAb, HBcAb <input type="checkbox"/> HCV Ab <input type="checkbox"/> HIV I & II <input type="checkbox"/> HTLV 1 and HTLV 2 <input type="checkbox"/> CMV/EBV <input type="checkbox"/> Varicella Zoster -If neg and not on immune-suppression needs vaccination followed by titre in 1mos <input type="checkbox"/> VDRL <input type="checkbox"/> Measels, Mumps, Rubella Titres. If neg needs booster and repeat titre in 1mos.	<input type="checkbox"/> Fasting Blood Sugar <input type="checkbox"/> HbA1C <input type="checkbox"/> CBC, INR, PTT <input type="checkbox"/> Electrolytes, Urea, Creatinine, eGFR <input type="checkbox"/> Cholesterol/Triglycerides, HDL/LDL <input type="checkbox"/> Calcium; Magnesium; Phosphate; Albumin <input type="checkbox"/> Total Protein, Amylase, Lipase <input type="checkbox"/> AST, ALT, ALP, Bilirubin <input type="checkbox"/> C-Peptide <input type="checkbox"/> 24 Hour Urine for CrCl & Protein X2 <input type="checkbox"/> Urine R&M, C&S, Cytology
TESTS (within the last year of referral date)	
<input type="checkbox"/> Chest X-Ray PA/Lateral <input type="checkbox"/> ECG 12 Lead (tracing must be included) <input type="checkbox"/> 2d Echocardiogram (repeat yearly) <input type="checkbox"/> Exercise Stress – MIBI (if pt unable then a Persantine Thallium or Dobutamine Stress Echo* is acceptable (should be within the year and then repeat yearly) <input type="checkbox"/> Carotid Dopplers	<input type="checkbox"/> Abdominal Ultrasound <input type="checkbox"/> Iliac Doppler Studies (repeat every 2 years) <input type="checkbox"/> If angiogram done please send report and CD <input type="checkbox"/> All pathology reports e.g. Kidney biopsy <input type="checkbox"/> Ankle Brachial Indices (Vascular lab at Victoria Hospital)
OTHER	
_ eGFR by MDRD (must be >60) _ Note from Ophthalmologist re: stability of Retina's _ Cancer Screening- Please send reports: PAP smear, Mammogram, PSA as per Ontario Guidelines	_ Height ____ Weight ____ _ Diabetic Questionnaire _ Colonoscopy if over age 50yrs or if over age 40yrs with family history of Colon cancer. _ Current Medication List

Process of Referral

Please send with a **REFERRAL LETTER** from the **Endocrinologist** including patient's complete demographics to:

Jessica McDougall, RN – T 519-663-3851 F 519-663-3858
 Diane Smith, RN – T 519-685-8500 x32331 F 519-663-3858

Transplant Recipient Coordinators
 University Hospital
 London Health Sciences Centre
 London, ON
 N6A 5A5

After receiving all this information we will then contact the patient and set up appointments as soon as possible. We will consider the patient's travel time; however, 1-2 trips to LHSC may be required to complete the assessment process.