St. Vincent's University Hospital	PATIENT NAME:

REFERRAL FOR PANCREAS/SIMULTANEOUS PANCREAS KIDNEY TRANSPLANT

DATE OF BIRTH:	TYPE OF DIALYSIS: NONE P.D. H.D. DAYS ON DIALYSIS: M TU W TH F SA SU EGFR:	ASSISTANCE REQUIRED? YES ☐ NO ☐ SPECIFY :
PREFERS TO BE ADDRESSED AS:	INTERPRETER NEEDED? YES ☐ NO ☐	MAIN LANGUAGE:

HEIGHT	WEIGHT	BMI	BP

PATIENT CONTACT DETAILS	FAMILY/NOK EMERGENCY CONTACT DETAILS
HOME	NAME
MOBILE	RELATIONSHIP
WORK	NOK CONTACT NUMBER
	NOK E-MAIL
E-MAIL	NOK ADDRESS
	NEXT OF KIN AWARE YES ☐ NO ☐ OTHER SIGNIFICANT FAMILY MEMBER: CONTACT NUMBER:

REFERRING CONSULTANT:	HOSPITAL:
ADDRESS:	TELEPHONE:
	MOBILE:
	FAX:

CONTACT DETAILS OF CNS COMPILING WORKUP:	NAME	EMAIL	PHONE

PLEASE ENCLOSE LETTERS FROM THE FOLLOWING

REFERRAL LETTER FROM NEPHROLOGIST	REFERRAL LETTER FROM ENDOCRINOLOGIST
☐	☐
LETTER FROM DENTAL PRACTITIONER (DENTALLY FIT)	LETTER FROM OPHTHALMOLOGIST
☐	☐

PLEASE COMPLETE THIS FORM AND ENCLOSE COPIES OF ALL REFERRAL LETTERS, AND TEST/INVESTIGATION RESULTS AND FORWARD TO:

THE PANCREATIC TRANSPLANT CO-ORDINATORS
ST. VINCENT'S UNIVERSITY HOSPITAL
ELM PARK
DUBLIN 4
TEL: 01-2213358
FAX: 01-2214568
E-MAIL: pancreas.transplant@svuh.ie

PANCREAS TRANSPLANTATION REFERRAL		PATIENT NAME:	
TEST	**DATE OF TEST**	**REPORT ENCLOSED/COMMENT**	**NOT DONE**
BLOODS			
FBC, U&E, eGFR, LFTs, Coag, Ca, PO4, Glucose, HbA1c, Chol, Trig, PTH, C-peptide, Anti-Gad, Amylase, Coeliac, blood group and cross match			
VIROLOGY			
HIV, Hepatitis A, B, C, D, CMV, EBV, HSV, VZV, TOXO, Syphilis, Measles, Mumps, Rubella IgG			
HLA ANTIBODY SCREENING			
TISSUE TYPE			
TISSUE TYPE CONFIRMATION			
ANTI HLA ANTIBODIES			
URINE			
URINALYSIS			
MSU			
IMAGING			
CXR			
NON-CONTRAST CT OF ABDOMEN AND PELVIS – TO ASSESS ARTERIAL CALCIFICATION			
LOWER LIMB INVESTIGATIONS – IF INDICATED (CLAUDICATION, ULCER, ABSENT PULSES)			
CARDIAC			
ECG			
ECHO			
EXERCISE TOLERANCE TEST			
CORONARY ANGIOGRAPHY (IF INDICATED OR EXERCISE TOLERANCE TEST UNSATISFACTORY OR EQUIVOCAL)			
DOBUTAMINE STRESS ECHO (IF INDICATED)			
RIGHT HEART STUDIES (IF INDICATED)			
MYOCARDIAL PERFUSION SCAN (IF INDICATED)			
RESPIRATORY			
PFT'S			
O_2 SATURATION LEVEL			

PANCREAS TRANSPLANTATION REFERRAL			PATIENT NAME:			
INVESTIGATIONS	DONE	NOT DONE	NOT REQUIRED	NORMAL	ABNORMAL	FURTHER ACTION
CERVICAL SMEAR TEST IF APPROPRIATE						
SKIN CHECK						
MAMMOGRAM (ALL ♀ OVER 50)						
PSA (ALL ♂ OVER 50)						
FOB, CEA OR COLONOSCOPY (ALL OVER 50 YRS)						
OTHER						

VACCINE RECORD * THIS INFORMATION SHOULD BE AVAILABLE FROM PATIENTS GP	**DATE GIVEN**	**DATE SCHEDULED**
INACTIVATED INFLUENZA		
HEP A (SUSCEPTIBLE PATIENTS)		
HEP B (IF HBSAG NEGATIVE AND ANTI-HBS<100MIU/L)		
HPV		
MENACWY		
MENB		
PCV		
PPV23 (2 MONTHS POST PCV)		
TDAP (DIPTHERIA, TETANUS, PERTUSSIS) (IF NOT RECEIVED WITHIN 10 YEARS) OR		
TDAP/IPV (USE IF NOT FULLY IMMUNISED WITH IPV)		
MMR (UNLESS LABORATORY EVIDENCE OF IMMUNITY OR DOCUMENTED PRIOR VACCINATION)		
VARICELLA (SERONEGATIVE PATIENTS)		

ALL VACCINES SHOULD BE GIVEN AT LEAST 1 MONTH PRIOR TO TRANSPLANT

*NATIONAL IMMUNISATION GUIDELINES FOR PRE-SOLID ORGAN TRANSPLANT

FURTHER INFORMATION AVAILABLE:
HTTP://WWW.HSE.IE/ENG/HEALTH/IMMUNISATION/HCPINFO/GUIDELINES/CHAPTER3.PDF
SOLID ORGAN TRANSPLANT CANDIDATES AND RECIPIENTS RECOMMENDATIONS PAGE 6-7

HTTP://WWW.HSE.IE/ENG/HEALTH/IMMUNISATION/HCPINFO/GUIDELINES/CHAPTER2.PDF
CATCH UP SCHEDULE FOR CHILDREN AND ADULTS: TABLE 2.3 ON PAGE 7

ON RECEIPT OF ALL THE ABOVE

ONCE WE HAVE RECEIVED **ALL THE REFERRAL LETTERS AND TEST/INVESTIGATION RESULTS** WE WILL CONTACT THE POTENTIAL RECIPIENT AND ARRANGE FOR THEM TO ATTEND ST. VINCENT'S UNIVERSITY HOSPITAL. AT THIS VISIT THEY WILL HAVE A CARDIO-PULMONARY EXERCISE TEST AND MEET THE PANCREAS TRANSPLANT CO-ORDINATORS, TRANSPLANTING SURGEON AND THE TRANSPLANT ANAESTHETIST. THIS WILL PROVIDE AN OPPORTUNITY FOR THEM TO MEET THE TEAM AND TO HAVE ANY QUERIES OR CONCERNS ADDRESSED.

NOTES/ADDITIONAL INFORMATION

PANCREAS TRANSPLANTATION REFERRAL	PATIENT NAME: