PRINT BLANK FORM | PRINT COMPLETED FORM AND RESET | RESET FORM

MUSC Health
TRANSPLANT CENTER

ASCREENCRIT

Referral for Pancreas Transplantation

Form Origination Date: 7/13
Version: 1 Version Date: 7/13

Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

Complete and return to:
MUSC Transplant Program
162 Ashley Avenue, MSC 586
Charleston, SC 29425
Fax: 843-876-2968
Email: PancreasTransplant@musc.edu

Date:_____

Patient Name: _____

Address: _____

Phone #: _____ Cell Phone #: _____

DOB:_____ Email Address: _____

Age: _____ Ht(cm): _____ Wt(kg): _____ Gender: _____ SS#: _____

Ethnicity:
☐ White
☐ American Indian/Alaska Native
☐ Hawaiian/Pacific Islander
☐ Asian
☐ Black/African American
☐ Hispanic/Latino
☐ Other: _____

Diagnosis: _____

Diabetes? ☐ Yes ☐ No Date / Age of Onset: _____ Insulin Dose: _____

Diabetic Complications: _____

Has patient ever had any of the following: heart attack, stroke, stent in the heart, or bypass? ☐ Yes ☐ No

Endocrinologist:_____

Address: _____

Comments from Endocrinologist concerning patient's candidacy for renal transplantation:

_____

_____

Referral should include:
☐ Completed referral form
☐ Clinical Documentation (H&P and/or Discharge Summary)
☐ Copy of insurance cards (front & back)
☐ Medication list
☐ Most recent labs; including a 24 hour urine for creatinine clearance and total protein

Endocrinologist Signature: _____ Phone # _____

Endocrinologist Name (Printed) _____

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