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|  |
| --- |
| * **Mandatory (all patients)**

** Select based on criteria: Prescriber check** (√) **to initiate, cross out and initial any orders not required.** |

* **Ensure Kidney Transplant referral module in PROMIS is initiated.**
1. **Transplant Program:**
* Vancouver General Hospital
* St. Paul’s Hospital
1. **Absolute Contraindications:**

|  |  |
| --- | --- |
| * **Do not proceed with transplant education if any of the following apply:**
 | * Active infection (e.g. TB)
* Active malignancy (excluding non-melanoma skin cancer)
* Oxygen dependent respiratory conditions
* Severe ischemic heart disease
* Severe peripheral vascular disease
* Uncontrolled cirrhosis
* Severe cognitive impairment
* Active drug or alcohol addiction
* Active non-compliance to therapy
* Uncontrolled psychiatric disorder
* Age>85

**\*Consult with nephrologist, if unable to clearly identify contraindications above.** |
| * **Consult with nephrologist about providing transplant education if any of the following apply:**
 | * Age 70 to 85
* eGFR not clearly declining
* Fluctuating compliance
* Extensive comorbidities
 |
| * **If none of the above criteria apply, proceed with transplant education**
 |

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1. **Mandatory Laboratory Tests for Referral Submission:**

**Note:** The following tests are **valid for 365 days**. If results are <365 days, those results can be used for referral submission, if >365 days those tests need to be repeated.

|  |  |
| --- | --- |
| * CBC, Sodium (Na), Potassium (K), Bicarb (CO2), Chloride (Cl), Total Bilirubin, Alkaline Phosphatase, eGFR, Creatinine, serum
* One of the following:
	+ Rapid Plasma Reagin (Syphilis)
	+ Treponema Pall AB EIA
* Hepatitis B Surface Antigen
* Hepatitis B Surface Antibody
* Hepatitis B Core Antibody
* HIV Serology
 | * Blood group/Rh
* Epstein Barr Virus IGG
* Hepatitis C Antibody
* HT Lymph Virus I/II (HTLV I/II)
* Cytomegalovirus IGG (CMV serology)
* Rubella IGG
* Mumps IGG
* Measels Antibody IGG
* Varicella Zoster Virus IGG
* SPEP (if >50 years of age)
 |

1. **Other Mandatory Tests for Referral Submission:**

|  |
| --- |
| * Chest X-ray within 2 years of referral submission (all patients)
* EKG within 2 years of referral submission (all patients)
	+ Echocardiogram within 2 years of referral submission (if >40 years of age)
 |
| * **One of the following screening cardiac tests** (All diabetics OR patients > 50 years of age OR any cardiac symptoms OR history of cardiac disease):
	+ - Stress echocardiogram **or**
		- MIBI **or**
		- Treadmill **or**
		- Coronary angiography

**Note:** If coronary angiography has been complete, the stress echocardiogram or MIBI or treadmill are not required. |
| A TB screening test is required for all patients unless a previous IGRA test has been done. IGRA is the standard test for TB screening.* + - IGRA, Chest X-ray **or**
		- TB screening already completed (with IGRA test) **or**
* Previous history of TB with treatment. Refer directly to BCCDC.
 |
| **Note:** Ensure all tests applicable to this patient based on the defined criteria below are uploaded into PROMIS: * FIT valid 2 years (FIT test if age >50. FIT not necessary if normal colonoscopy in the last 5 years)
	+ Mammogram valid 2 years (females age 50-74) if not complete follow-up with primary care
* PAP smear valid 3 years (females age 25-69), self-performed also accepted
 |
| * **Dental:** Inform all patients of requirement to ensure dental check-ups are up to date
 |

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1. **Verify and update or enter the following information in PROMIS:**

|  |  |
| --- | --- |
| **Patient demographics** | * Phone
* English Ability
* Race
* Need Translator
* Blood Type, Blood Rh
* Height and Weight
* Ambulatory Y/N
 |
| **Physicians** | * Family physician
* Primary nephrologist
 |
| **Drug Allergies and Medications** | * Drug allergies
* Current Medications
 |
| **Screening** | * Previous blood transfusions
* Prior pregnancies
* Prior transplants
* Renal Biopsies
* Primary Renal Disease Diagnosis
* Living donor discussion occurred
* Potential living donor identified by transplant candidate
 |

|  |  |  |  |
| --- | --- | --- | --- |
| DATE (DD/MM/YYYY) | TIME | PRESCRIBER NAME (PRINTED) OR COLLEGE ID | PRESCRIBER SIGNATURE |