

ISLET TRANSPLANT REFERRAL FORM

(Type 1 Eligible)

PCIS LABEL

Referral Date: _____

Last name: _____ First name: _____

Sex: male female Race: _____

PHN: _____ DOB: _____

Address: _____ Postal Code: _____

Home phone: _____ Cell phone: _____

Contact name: _____ Relationship: _____ Phone: _____

Referring Physician: _____ Phone: _____ Fax: _____

General Practitioner: _____ Phone: _____ Fax: _____

Address: _____

Other Specialists involved with care: _____

Age Diabetes Diagnosed _____ Insulin Type & Doses _____

Previous Kidney Transplant? No Yes Date: _____ Donor-Living _____ Deceased _____

Previous Islet Transplant? No Yes Date: _____

Height: _____ Weight: _____

Does the patient speak English? Yes No, if no what language? _____

Special needs? _____

Please Mail to: (✓ check one)

Clinical Coordinator, Islet Cell Program
Pre-Assessment Transplant Clinic
Gordon and Leslie Diamond Health Centre
5th Floor, 2775 Laurel Street
Vancouver, BC V5Z 1M9
Tel: 604-875-5182
Fax: 604-875-5236

CHECKLIST FOR ACCOMPANYING INFORMATION

Patient Name: _____ DOB: _____

A) Please include if available:

Information regarding medical history

Consult notes (endocrinology, ophthalmology, neurology, etc.)

Lab work including:

- **Chemistry:** Na, K, Cl, bicarb, Albumin, Total protein, Ca, MG, PO4, Uric acid, CK, Creatinine, Urea, HbA1C, GGT, AST, ALT, Alk phos, Amylase, Total Bili, Direct Bili, LDH, fasting blood glucose, homocysteine.
- **Hematology:** CBC and Differential, Platelets, INR, PTT
- **Iron Studies:** total iron, ferritin, TIBC, iron saturation
- **Urine Studies:** 2 X 24 hour urine for creatinine clearance and microalbuminuria and ratio, urine R&M
- **Lipid Studies:** Total Cholesterol, LDL, HDL, and Triglycerides
- **C-Peptide**
- **TSH**

Last eye exam

Psychosocial concerns and notes

Other relevant test results such as cardiac studies, nerve conduction studies, etc.