

# Referral Orders for Kidney Transplant Assessment (Adult)

Form ID: \_\_\_\_\_ Rev: June 2026 Page 1 of 3

## PATIENT INFORMATION LABEL

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_\_

PHN: \_\_\_\_\_

- 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. 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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## 2. Mandatory Laboratory Tests for Referral Submission:

**Annual Tests (valid for 365 days):** Repeat if results are older than 365 days at the time of referral submission.

- CBC, Sodium (Na), Potassium (K), Bicarb (CO<sub>2</sub>), 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
- Hepatitis C Antibody
- HT Lymph Virus I/II (HTLV I/II)
- HIV Serology

### One-Time/Conditional Tests:

- Epstein Barr Virus IGG
- Cytomegalovirus IGG (CMV serology)
- Rubella IGG
- Mumps IGG
- Measles Antibody IGG
- Varicella Zoster Virus IGG
- Blood group/Rh
- SPEP if >50 years of age

## 3. 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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### 4. Verify and update or enter the following information in PROMIS:

<b>Patient demographics</b>	<ul style="list-style-type: none"> <li>• Phone</li> <li>• English ability</li> <li>• Race</li> <li>• Need translator</li> <li>• Blood type, Blood Rh</li> <li>• Height and Weight</li> <li>• Ambulatory Y/N</li> </ul>
<b>Physicians</b>	<ul style="list-style-type: none"> <li>• Family physician</li> <li>• Primary nephrologist</li> </ul>
<b>Drug Allergies and Medications</b>	<ul style="list-style-type: none"> <li>• Drug allergies</li> <li>• Current medications</li> </ul>
<b>Screening</b>	<ul style="list-style-type: none"> <li>• Previous blood transfusions</li> <li>• Prior pregnancies</li> <li>• Prior transplants</li> <li>• Renal biopsies</li> <li>• Primary renal disease diagnosis</li> <li>• Living donor discussion occurred</li> <li>• Potential living donor identified by transplant candidate</li> </ul>

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