BCRenal
Provincial Health Services Authority

Referral Orders for Kidney Transplant Assessment (Adult)

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. **Transplant Program:**
   - ☐ Vancouver General Hospital
   - ☐ St. Paul's Hospital
2. **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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3. **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 (CO_2), Chloride (Cl), Total Bilirubin, Alkaline Phosphatase, eGFR, Creatinine
- One of the following:
  - ☐ Rapid Plasma Reagin (Syphilis) or
  - ☐ 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
- Measles Antibody IGG
- Varicella Zoster Virus IGG
- ☐ SPEP (if ≥50 years of age)

4. **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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5. <u>Verify and update or enter the following information in PROMIS:</u>

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