Form ID: Rev: September 2023 Page 1 of 3

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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** | |

Form ID: Rev: September 2023 Page 2 of 3

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:**

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| --- |
| * Chest X-ray within 6 months of referral submission (all patients) * EKG within 6 months of referral submission (all patients)   + Echocardiogram within 1 year 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) if not complete follow-up with primary care |
| * **Dental:** Inform all patients of requirement to ensure dental check-ups are up to date |

Form ID: Rev: September 2023 Page 3 of 3

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 |

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