TRANSPLANT REFERRAL FORM

Referral will be delayed if all of the items below are not included:

Referred for: ☐ Kidney ☐Pancreas ☐Kidney/Pancreas

Diabetic: Yes ☐ No ☐ Type 1 ☐ Type 2 ☐

MUST include/fax the following information: **Date:** ______________

- ☐ History and physical
- ☐ Medication List
- ☐ Current Labs
- ☐ Legible Copies of ID and ALL insurance cards (Including VA, Medicare, Medicaid etc.)
- ☐ Completed Post Transplant Care Support Form
- ☐ Completed Transplant Candidate Questionnaire
- ☐ CMS 2728 Form
- ☐ Immunization Records
- ☐ Completed/Signed PHI consent

Legal Name: Last__________________ **First**______________ **Preferred Name:**__________________

Male ☐ **Female** ☐ **Height:**_________ ☐in/☐cm **Weight:**_______ ☐kg/☐lbs. **BMI:**_________

Address:________________________________ **City:**_____________ **State:**____ **Zip:**_________

Phone: Cell:_______________ **Home:**________________ **Email:**_________________________

Primary Language:☐ English ☐Spanish ☐Other:_____________ **Date of Birth:** ___________

Patient Race:____________ **Ethnicity:** _____________ **Social Security Number:**_________________

Insurance(s):____

Referring Physician:_____________________________ **Phone:**_____________ **Fax:**_____________

Dialysis Unit: _________________________________ **Phone:** ______________ **Fax:** _______________

Specific Location/Address:____

Social Worker/Case Manager: __________________________ Email :___________________________

Dialysis Type: ☐HEMO ☐PD ☐NOT on dialysis; **Dialysis Start Date:**________ **Most current GFR:**______

Does the patient have a living donor? ☐Yes ☐No

Patient has established care with PCP? (Has been seen within the past year) ☐Yes ☐No

PCP Name: ____________________________ **Phone:**________________ **Fax:**_________________

PLEASE COMPLETE ENTIRE FORM AND FAX TO 702-383-1876

UMC TRANSPLANT REFERRAL TEAM **Phone: 702-224-7130**

TransplantReferrals@umcsn.com

901 Rancho Lane, Suite 250 Las Vegas, NV 89106

Revised 2/2022

REFERRAL CRITERIA FOR KIDNEY/PANCREAS TRANSPLANT RECIPIENT

The following are criteria for selection for renal transplant candidates.

Inclusion Criteria:

- End Stage Renal Disease with a GFR ≤20 ml/min or is on dialysis.
- End Stage Renal Disease with a GFR ≤30 ml/min for living donor transplants.
- Psychosocial stability and supportive family/social structure as defined by social assessments.

Absolute Exclusion Criteria:

- Active Infection
- Active Malignancy
- Current Cigarette smoking as per self-report/ failing nicotine cotinine test
- Active untreated psychiatric illness
- Active untreated substance abuse

Relative Exclusion criteria:

- Severe coronary artery disease
- HIV infection
- Severe left ventricular dysfunction
- Severe chronic obstructive pulmonary disease
- Recent history of malignancy
- Cirrhosis/liver dysfunction
- Active peptic ulcer disease
- Coagulopathy/anti-coagulated state
- Extensive peripheral vascular disease
- Morbid obesity
- Multiple co-morbidities
- Non-adherence
- Active psychiatric illness or psychological instability
- Lack of identified support person
- Inadequate insurance coverage

If the patient does not meet selection criteria or is not selected by the committee for placement on the kidney wait list, the patient, referring physician and dialysis center will be notified with the rationale.

If the patient meets criteria and receives committee approval, the patient, referring physician and dialysis center will be notified that the patient is being listed.

Revised 2/2022

TRANSPLANT CANDIDATE QUESTIONNAIRE

IMPORTANT NOTE: Information provided in this questionnaire is strictly confidential and becomes a part of your medical record. Complete every line. If it does not apply put "N/A".

PERSONAL

Patient Name:	Date of Birth:
Maiden / Other Name(s):	Social Security #:
Street Address:	Home Phone #:
City: State: Zip:	Work Phone #:
County: Country:	Cell Phone #:

EMPLOYMENT

Employment Status: ❑ Employed ❑ Unemployed ❑ Student ❑ Retired ❑ Disabled ❑ Homemaker
Occupation:______________________ Employer:______________________

CITIZENSHIP (check one box)

❑ U.S. Citizen ❑ Resident Alien ❑ Non-Resident Alien → Date you entered the United States:_

LANGUAGE & LEARNING

Please check ANY of the following that apply:
❑ I speak English. ❑ I speak: ______________________

REFERRAL

Referred by: ❑ Self ❑ Dialysis Unit ❑ Physician: Name: Phone: Fax:

DIALYSIS

Are you on Dialysis? ❑ Yes ❑ No → *If Yes, complete the following information. If No, skip to the next section.*

a. Dialysis Schedule: ❑ Mon ❑ Tue ❑ Wed ❑ Thu ❑ Fri ❑ Sat Time:_____
b. Type: ❑ Hemodialysis ❑ Peritoneal Dialysis ❑ Home Hemodialysis
c. Dialysis Unit:______________________ Phone:_________ Fax:____________

MEDICAL

What is the cause of your kidney failure?______________________

TRANSPLANT: Are you listed with another Transplant Center? ❑ Yes ❑ No;
Where?_______________ Phone: _______________
Have you had a transplant before? ❑ Yes ❑ No Organ: Date:
Where:
Have you had a kidney biopsy? ❑ Yes ❑ No; Where?_______________

INFECTION

1. Have you had infections in your **bladder or kidneys**? ❑ Yes ❑ No
2. Do you currently have **dental** issues? ❑ Yes ❑ No Date of most recent exam: _______________
3. Do you currently have **another** infection? ❑ Yes ❑ No; What? _______________
4. Do you have **active**: **TB**? ❑ Yes ❑ No **Hepatitis B**? ❑ Yes ❑ No **Hepatitis C**? ❑ Yes ❑ No
   Treated?

RESPIRATORY

1. Do you have **COPD**? ❑ Yes ❑ No; **Emphysema**? ❑ Yes ❑ No;
2. Do you use **oxygen**? ❑ Yes ❑ No; When? _______________
3. Have you had a **Pulmonary Function Test**? ❑ Yes ❑ No;
4. Do you have **sleep apnea**? ❑ Yes ❑ No;

TRANSPLANT CANDIDATE QUESTIONNAIRE

MRA01811

5. Do you use **CPAP**? ❑ Yes ❑ No

CANCER HISTORY

Have you ever had Cancer? ❑ Yes ❑ No → *If Yes, complete below. If No, skip to next section.*

a. What kind?____________________ Any skin cancer (specify type):____________________.

b. Date of first Diagnosis:________

c. Treatment (check all that apply): ❑ NONE ❑ Surgery ❑ Radiation ❑ Chemotherapy ❑

*Treating Physician:*________________________ *Phone:*____________ *Fax:*____________

*Treating Facility:*________________________ *Phone:*____________ *Fax:*____________

d. Date of Treatment Completion: ❑ N/A – still being treated ❑ N/A – did not receive treatment

HEART HISTORY

High blood pressure ❑ Yes ❑ No Congestive heart failure ❑ Yes ❑ No

Low blood pressure ❑ Yes ❑ No Problems with circulation ❑ Yes ❑ No

Stent ❑ Yes ❑ No Angina (chest pain) ❑ Yes ❑ No ❑ NONE of these

❑ Other (specify):____

HEART HISTORY CONTINUED

1. Have you ever had an Electrocardiogram (EKG)? ❑ Yes ❑ No
2. Have you ever had an **Echo**cardiogram? ❑ Yes ❑ No
3. Have you ever had a Stress Test? ❑ Yes ❑ No
4. Have you ever had an Angiogram / Heart Catheter? ❑ Yes ❑ No
5. Do you go to a cardiologist? ❑ Yes ❑ No Name:

____

6. Have you ever had a Stroke? ❑ Yes ❑ No *Date:*________ *Hospital:*____________

List any problems you still have:

DIABETES HISTORY

1. Have you ever been diagnosed with Diabetes? ❑ Yes ❑ No → *If Yes, how long ago?*__________
2. Are you legally blind? ❑ Yes ❑ No
3. Do you have neuropathy (numbness / tingling of extremities)? ❑ Yes ❑ No
4. Do you have problems with non-healing foot ulcers? ❑ Yes ❑ No
5. Do you currently have any open wounds or ulcers on your legs, feet or toes? ❑ Yes ❑ No
6. Have you had any amputations? ❑ Toe/s ❑ Foot ❑ Leg

NEUROLOGIC & MENTAL HEALTH

1. Have you ever seen a psychologist or psychiatrist? ❑ Yes ❑ No → *If Yes,*

   *Name/s:*________________________ *Phone:*______________ *Fax:*______________
2. Do you have a history of depression? ❑ Yes ❑ No

   *Describe:*____
3. Do you take any psychiatric or depression medications? ❑ Yes ❑ No, What?
4. Have you ever taken any medications for seizures? ❑ Yes ❑ No, What?

TRANSPLANT CANDIDATE QUESTIONNAIRE

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PERSONAL HEALTH INFORMATION

BLOOD PRODUCTS Will you accept them if needed? ❑ Yes ❑ No

SMOKING

1. Do you **currently** smoke? ❑ Yes ❑ No; What? ______________ Do you use tobacco? ❑ Yes ❑ No; What?______________
2. Have you **ever** used or smoked tobacco? ❑ Yes ❑ No; How long? When did you quit?
3. Do you currently use alcohol?❑ Yes ❑ No; What? ______________ Do you use drugs? ❑ Yes ❑ No; What?______________

MOBILITY

1. Do you drive and have access to a **car**? ❑ Yes ❑ No *If No, do you have access to <u>reliable</u> transportation?* ❑ Yes ❑ No
2. Do you regularly **exercise**? ❑ Yes ❑ No; What do you do? ______________
3. Can you: **Dress** without help? ❑ Yes ❑ No;
   Bathe without help? ❑ Yes ❑ No;
   Climb Stairs without help? ❑ Yes ❑ No;
   Walk Around The Block? ❑ Yes ❑ No;

   Do you require a **Wheelchair or Walker**? ❑ Yes ❑ No; Describe:

INSURANCE INFORMATION

1. Are you covered by insurance? ❑ Yes ❑ No → *If Yes, complete the following. If No, skip to #2.*
   a. Primary Insurance:______________________
   Check all that apply: ❑ Group Plan ❑ Cobra Plan
   Employer:______________________
   Subscriber's Name:______________________
   Subscriber's SSN:______________________
   Policy Number:______________________
   Insurance Company Phone #:______________
   b. Secondary Insurance:______________________
   Check all that apply: ❑ Group Plan ❑ Cobra Plan
   Employer:______________________
   Subscriber's Name:______________________
   Subscriber's SSN:______________________
   Policy Number:______________________
   Insurance Company Phone #:______________
2. Are you covered by Medicaid? ❑ Yes ❑ No → *If Yes, Medicaid #:* ______________
3. Are you covered by Medicare? ❑ Yes ❑ No → *If Yes, Medicare #:*___
4. Other Medical Coverage (please list):______________________________
5. Are you a Veteran? ❑ Yes ❑ No → *If Yes, do you have Veteran's Health Benefits?* ❑ Yes ❑ No
6. Monthly Household Income & Source(s):______________________________

   ____
7. Number of people living at home:__ / Number of dependents:___
8. **Please provide copy of insurance cards.**

TRANSPLANT CANDIDATE QUESTIONNAIRE

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DOCTORS & HOSPITALIZATIONS

List all doctors you see:

	Doctor	What kind of doctor?
1.	______,	______.
2.	______,	______.
3.	______,	______.
4.	______,	______.
5.	______,	______.
6.	______,	______.
7.	______,	______.
8.	______,	______.

List surgeries, hospitalizations or ER visits:

Year	Hospital
1.	______, ______.
2.	______, ______.
3.	______, ______.
4.	______, ______.
5.	______, ______.
6.	______, ______.
7.	______, ______.
8.	______, ______.
9.	______, ______.

Time:________ Date:________ Patient / Legal Representative Signature:________________________

*(If completed by someone other than the patient, print person's name here):*________________________

PLACE PATIENT LABEL TO COVER OR COMPLETE BELOW:

Patient Name:__________

DOB:______ Age:______ Sex:______

CSN:__________

MRN:__________

PROTECTED HEALTH INFORMATION (PHI) RELEASE AUTHORIZATION

MRU00695 (01/29/19)

Patient's Name:__________ Date of Birth:______ SS # *(optional)*:______

Street Address:__________ City:______ State:____ Zip Code:____

Phone #:______ Alt. #:______ Email Address:__________

I authorize the following facility(ies) to release my Protected Health Information (PHI) for the specified dates of service:

- ❑ University Medical Center of Southern Nevada main hospital campus (UMC) → Dates of Service:______
- ❑ UMC Quick Care† *(specify locations)*:______ → Dates of Service:______
- ❑ UMC Primary Care† *(specify locations)*:______ → Dates of Service:______

I authorize the following PHI to be released from my medical record (check all that apply):

❑ Abstracts/Summaries (includes: Discharge Summary, History and Physical, Operative Reports, Consultations and Test Results)

❑ Emergency Room Record ❑ Radiology Reports ❑ Radiologic film / digital imaging

❑ Test Results of *(specify)*:______ ❑ Other *(specify)*:______

The information in my health record may include information relating to sexually transmitted disease, mental health services, and treatment of alcohol or drug abuse. State and federal law protect the following information. If this information applies to you, please indicate if you would like this information to be released / obtained, include dates of service where appropriate and then initial each line:

- Alcohol, Drug, or Substance Abuse ❑ Yes ❑ No → Dates of Service:______ Initials:____
- HIV Testing and Results ❑ Yes ❑ No → Dates of Service:______ Initials:____
- Mental Health Records ❑ Yes ❑ No → Dates of Service:______ Initials:____
- Psychotherapy Records ❑ Yes ❑ No → Dates of Service:______ Initials:____
- Genetic Records ❑ Yes ❑ No → Dates of Service:______ Initials:____

I request that my PHI be disclosed to the following person: ❑ Patient (self) ❑ Other recipient (complete below)

Recipient's Name *(ONE per request)*: UMC Center For Transplantation Phone #: 702-224-7130

Street Address: 901 Rancho Lane, Suite 250 City: Las Vegas State: NV Zip Code: 89106

Email Address *(optional)*:__________ Fax #: 702-868-1666

Purpose for requesting the release of my PHI (select one): ❑ Legal ❑ Insurance ❑ Personal ❑ Continuation of Care

❑ Other purpose *(specify)*:__________

Disclosure Format: ❑ Paper *(default if none selected)* ❑ CD-ROM / disc ❑ Email

Disclosure Method: ❑ Call for pick-up ❑ Send via US Mail ❑ Send via Fax ❑ Other / Spec. Req.:______

This authorization will expire *one year from the date of signature (default)* or on the following date / event / condition:

Date / Event / Condition *(specify)*: Until discharged from the UMC Transplant Center

By signing this authorization form, I understand that:

1. Requests for copies of medical records are subject to reproduction fees in accordance with federal / state regulations.
2. Authorizing this release of information is voluntary and I may refuse to sign this document.
3. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
4. I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the UMC Health Information Management Department at the following address: *1800 W. Charleston Blvd., Las Vegas, Nevada 89102.* Revocation will not apply to information that has already been disclosed in response to this authorization.
5. The information disclosed pursuant to this authorization may be subject to re-disclosure and therefore no longer protected by federal privacy regulations.

Time:______ **Date:**______ **Patient or Patient Representative's* Signature:**__________

Patient Representative's Name (if applicable):__________ **Relation to Patient:**______

**(Note: Guardians and Durable Power of Attorney designees should include a copy of the applicable paperwork with this request.)*

ORIGINAL: Medical or Billing Record COPY: Patient or Patient's Legal Representative †See reverse for a list of locations

Patient:

DOB:

Post Transplant Care Support

Thank you for choosing University Medical Center of Southern Nevada for your transplantation needs. We strive for the best patient care. Following your transplant, it is necessary to maintain a relationship with our transplant program and medical community here in Las Vegas for up to 12 months. Patients need to have the ability to maintain their follow up care with the program. We require additional information in order to serve you better. Please fill out the following so we may best assess your care post transplant and return it with your Health History Questionnaire and the Authorization to Release Protected Health Information form.

1. Who is going to be your personal caregiver(s) in the Las Vegas area following your kidney transplant?

Name	Relationship	Contact Information

2. If you are from outside the greater Las Vegas area, what is your plan to establish housing in Las Vegas after your kidney transplant?

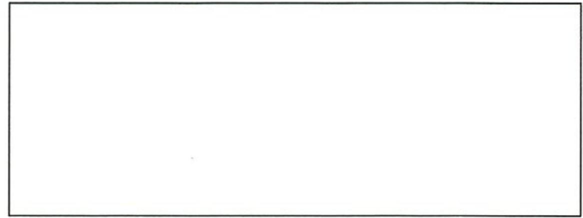
3. Who is your Primary Care Physician?

Name	Telephone Number

Patient's Signature ____________________ Date ____________________

Signature ____________________ Date ____________________

If Patient did not complete form, name of person who completed this form



UMC Center for Transplantation
901 Rancho Lane, Suite 250
Las Vegas, NV 89106

Dear Transplant Education Attendee,

You are scheduled to attend our **virtual** transplant education class. This class is required to move forward in the transplant process.

- UMC Transplant Coordinator
- UMC Transplant Dietitian
- UMC Transplant Financial Counselor
- UMC Transplant Living Donor Coordinator
- UMC Transplant Nephrologist
- UMC Transplant Pharmacist
- UMC Transplant Social Worker
- UMC Transplant Surgeon

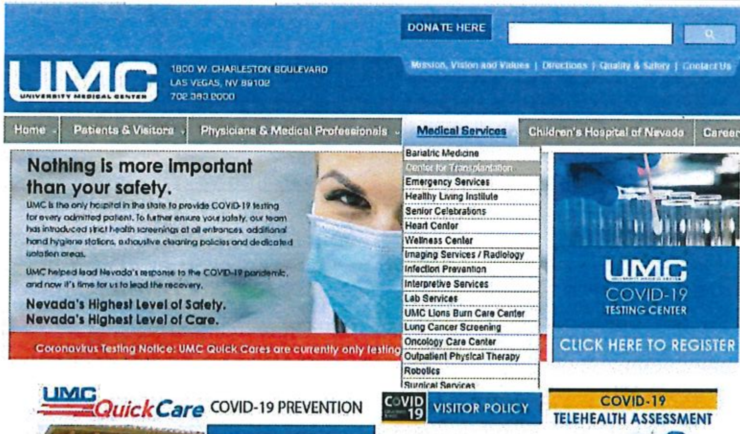
To help you understand the transplant journey here at the UMC Center for Transplantation you will need to complete all 8 parts of the video class. These 8 videos constitute the "Transplant Class" and all must be viewed prior to moving forward on your transplant journey. Please let us know when you have viewed all 8 of the videos and signing the "virtual education class acknowledgement" form and returning it.

Sincerely,

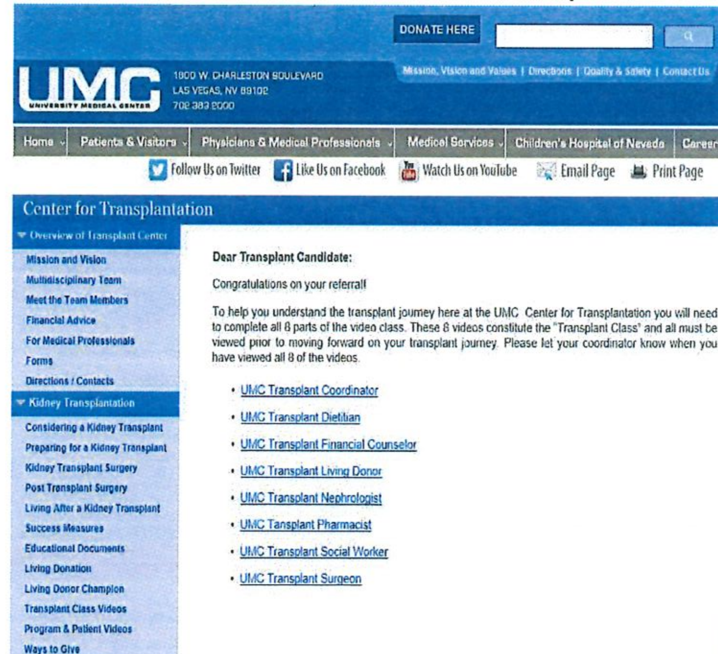
Transplant Services Staff
University Medical Center
P: (702) 383-2224
F: (702) 383-1876
Email: TransplantReferrals@umcsn.com

<u>Step #1</u> - Visit www.umcsn.com

<u>Step #2</u> - CLICK on "<u>Medical Services</u>" tab, then CLICK on "<u>Center for Transplantation</u>"



<u>Step #3</u> - On the left side of the screen CLICK "Transplant Class Videos"



VIDEO CLASS
ACKNOWLEDGEMENT

Name:
DOB:

I ______________________________________ have watched ALL 8 UMC Kidney Transplant Education

(Patient Name – Please Print)

Class videos, presented on www.umcsn.com.

The following topics were presented and discussed during the education videos.

Video on UMC Center for Transplantation

Video PowerPoint Presentation which included:

- UMC Transplant Coordinator
- UMC Transplant Dietitian
- UMC Transplant Financial Counselor
- UMC Transplant Living Donor Coordinator
- UMC Transplant Nephrologist
- UMC Transplant Pharmacist
- UMC Transplant Social Worker
- UMC Transplant Surgeon

By signing below, I acknowledge that I have watched the videos and that I understand the information.

Patient / Guardian Signature: ______________________________ Time: _______ Date: ________

Please return in the self-addressed stamped envelope provided or Fax to the number below.

901 Rancho Lane, Suite #250
Las Vegas, NV 89106
UMC Center for Transplantation
Phone: (702) 383-2224
Fax: (702) 383-1876
Email: TransplantReferrals@umcsn.com

Patients are required to complete preventive health maintenance **prior to evaluation testing**. Please work with your PCP/insurance company to complete preventive health maintenance that applies to you. The list below describes all preventive health maintenance testing that the candidate may have to perform. Please review testing description below to determine which tests you need to complete.

- **Colonoscopy** required for patients:
  - 50 years old or above
  - *Results must state the length of time when a repeat colonoscopy is required*
  - *Cologuard will not be considered as a valid screening option*
- **Yearly Mammogram** required for female patients:
  - 40 years old or above
- **Yearly PAP Smear** required for female patients:
  - 18 years old or above
- **Yearly Dental Clearance** required for all patients
  - Dental clearance form attached- need medical clearance from your Dentist
- **Immunization Records** required for all patients:
  - Hepatitis A x 2 doses (six months apart)→ NOT offered at dialysis
  - Tetanus (TDAP) – required every 10 years→ NOT offered at dialysis
  - Pneumonia – required every 5 years
  - Hepatitis B x 4 doses or have antibodies
  - Flu Shot – required yearly
- **TB Skin Testing Record:** required yearly for all patients

Please save the above testing and submit when requested by your Transplant Coordinator.

Dental Clearance

TO: UMC CENTER FOR TRANSPLANTATION
901 RANCHO LAVE, SUITE 250
LAS VEGAS, NV 89106
FAX: 702-383-1876

_____________________ has completed his/her dental examination. He/she does not have any infection that would prevent him/her from having a kidney transplant and taking immunosuppressive medication.

Please circle one: Cleared / Not Cleared

State reason if not cleared:

FROM: ________________________________ ______________
DDS SIGNATURE DATE

- **PRINT DDS FULL NAME** ________________________________
- **FACILITY NAME** ________________________________
- **PHONE NUMBER** ________________________________

If you are having difficulty in obtaining a dental clearance, the following dental offices may be able to assist you in completing your dental clearance:

- **Dentist on Nellis**
  Phone: (702) 457-5335

- **Dr. Erick Bernsweig, D.D.S, M.S**
  Phone: (702) 869-8200 or (702) 228-6684

- **UNLV School of Dental Medicine**
  Phone: (702) 774-5175
  - Inform the dental office that you are currently undergoing testing for transplant with UMC Center for Transplantation.
    - Complete exam with X-ray: $135
    - Deep cleaning: prices vary
    - Regular cleaning: $75
    - You may bring your own X-rays if you have already completed them.

- **Dental Faculty Practice:**
  Phone: (702) 651-5510
    - Complete exam with X-ray: $99
    - Cleaning with dental students:
      - Deep cleaning: $80
      - Regular cleaning: $25 – $30

The above prices are only an estimate, please contact the dental offices directly to determine exact cost. These clinics may offer an affordable option, however, please check with your insurance to determine what your out of pocket expenses will be. Please keep in mind that you are responsible for any fees associated with any dental procedure you may have.

TRACKING MY PROGRESS

Please Keep this form in a visible place for you to remember.

ALL APPROPRIATE TESTING MUST BE COMPLETED PRIOR TO RECEIVING AN EVALUATION APPOINTMENT. PLEASE FAX THIS FORM TO 702-383-3035 WHEN COMPLTED.

Patient Name: ______________________________ D.O.B: __________

- **Colonoscopy**
  - Date of Exam: ________
  - Physician Name: ____________________
  - Phone: _________________ Fax: __________________

- **Mammogram**
  - Date of Exam: ________
  - Physician Name: ____________________
  - Phone: _________________ Fax: __________________

- **PAP Smear**
  - Date of Exam: ________
  - Physician Name: ____________________
  - Phone: _________________ Fax: __________________

- **Dental Exam**
  - Date of Exam: ________
  - Physician Name: ____________________
  - Phone: _________________ Fax: __________________

- **Immunization Records**
  - Hepatitis A x 2 doses: Dose Date #1 : __________ Date Dose #2 : __________
  - Tetanus (TDAP): Date __________
  - Pneumonia: Date __________
  - Hepatitis B x 4 doses: Dose #1 : _______Dose #2 : _______ Dose #3 : _______ Dose #4_______
  - Flu Shot: Date ___________

Transplant Living

Because every part of the transplant experience is as unique as the individual experiencing it

Whether you are an organ transplant candidate, recipient, living donor, family member or healthcare professional, your information needs are unique.

That's why United Network for Organ Sharing (UNOS) designed Transplant Living, a comprehensive education program created to provide accurate, unbiased, and easy-to-understand information to help all audiences learn more about the transplant experience.

Whether you need information about how organ matching works or want tips on adjusting to life after transplant, we provide free educational resources and support through:

- Web sites
- E-mail newsletters
- Booklets and brochures
- Assistance by phone

No matter where you are in your transplant journey, Transplant Living can help you prepare. We'll provide you with the information, resources, support and tools to help you manage your health information needs.

- Access information and resources specific to your needs
- Learn about the organ matching process
- Read inspiring stories of hope from recipients
- Find out the details about living donation
- Research funding sources to help with the costs of transplant
- Learn how to manage medications and their side effects
- Get wellness and lifestyle tips
- Find support groups and events in your area
- Get the latest news in our monthly e-newsletter
- Order additional print resources from our online store

www.transplantliving.org www.transplantesyvida.org

888-894-6361 • info@transplantliving.org