HEALTH NET
TRANSPLANTATION REQUEST
KIDNEY/PANCREAS

Patient:_____ Age:_____ Date: _____

Member #: _____

Transplant Type: _____

Etiology of Organ Failure: _____

Attending Physician: _____

Phone: _____

Fax: _____

Form Completed By: _____

Title: _____

Phone: _____

Fax: _____

ATTENDING PHYSICIAN ATTESTATION

The responses in this document have been reviewed and are accurate.

_____
(Signature)

_____
(Date)

HEALTH NET
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KIDNEY/PANCREAS

PATIENT CLINICAL PROFILE

CLINICAL HISTORY

_____

_____

_____

DOCUMENTATION OF END-STAGE PANCREATIC DISEASE

Medications (dose/response) during the past 24 months

_____

_____

_____

Present Medications (dose/response)

_____

_____

_____

Diabetic Complications

	YES	NO	DOCUMENTATION
Renal Failure	_____	_____	_____
Retinopathy	_____	_____	_____
Neuropathy	_____	_____	_____
Cardiovascular	_____	_____	_____
Peripheral Vascular Disease	_____	_____	_____
Neurovascular Disease	_____	_____	_____

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Does the patient have insulin resistance? Yes _____ No _____

What is the patient's blood pressure? _____

DOCUMENTATION OF END-STAGE PANCREATIC DISEASE (CONT.)

Has the patient had?

	YES	NO	RESULT
Thallium Treadmill	____	____	_____
Coronary Angiogram	____	____	_____

OTHER MEDICAL FACTORS

Does the patient have?

	YES	NO	DOCUMENTATION
Cardiac Dysfunction	_____	_____	_____
Liver Dysfunction	_____	_____	_____
Pulmonary Dysfunction	_____	_____	_____
Active Infection	_____	_____	_____
Prior History of Malignancy	_____	_____	_____
Active Peptic Ulcer Disease	_____	_____	_____

LAB TESTS

Hob A1C Current: _____ 6 mos. ago: _____ 1 yr. ago: _____

Hepatitis B
Antigen Positive: _____ Negative: _____

Antibody Positive: _____ Negative: _____

HIV Positive: _____ Negative: _____

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Psychosocial background, including history of alcohol or drug abuse:

Other Comments: