

Renal Transplant Waiting List Referral

Please return to
Transplant Nurse Team
Department of Renal Medicine
Level 03, Derriford Hospital
Plymouth PL6 8DH

Dear Transplant Team

Please can the above named patient be assessed for suitability to enter the Renal Transplant Waiting list. *(delete as necessary or ✓ box accordingly to indicate enclosed documents).*

Renal Diagnosis;		Other diagnoses;	
? Previous transplants.	Yes/No	If yes, how many?	<input type="text"/>
Dialysis status; CRF/HD/CAPD		Dialysis unit; Plymouth/Cornwall/Exeter/Dorset	
All Patients CXR. Date; (enclose copy of report)	<input type="text"/>	All Patients ECG. Date; (enclose copy of report)	<input type="text"/>
Diabetic Type <input type="text"/> / Type <input type="text"/>	Yes/No	IF YES ECHO plus MIBI or ETT Date; (enclose copies of reports)	<input type="text"/>
		IF YES ? NEED VASCULAR ASSESSMENT Date; (enclose copies of reports)	<input type="text"/>
Aged > 50 years?	Yes/No	IF YES ECHO plus MIBI or ETT Date; (enclose copies of reports)	<input type="text"/>
RECENT; WEIGHT.....kg HEIGHT;.....CM BMI.....	Other surgical procedures? Details;		
	Procedure	Date:	
	Procedure	Date:	
	Procedure	Date:	
? Unexplained breathlessness	Yes/No	IF YES ? Need for lung function tests. Date; (enclose copies of reports)	<input type="text"/>
Signed; Name (print)	Date	Any other info	