

Radiology Review – Kidney/Pancreas Transplant

Outside Imaging Facility: _____ Coordinator: _____

Patient's Name: _____

MHD#: _____ MHD# _____

DOB: _____ Diagnosis: _____

Films for Review/ Date:

CT: _____ MRI: _____

U/S: _____ Other _____

Medical History: Pre-Transplant Post-Transplant

Question: _____

Reviewed by: _____ Date: _____

Impression/Recommendation _____
