Radiology Review – Kidney/Pancreas Transplant

Outside Imaging Facility:_____Coordinator:_____

Patient's Name: _____

MHD#: _____

DOB:_____Diagnosis: _____

Films for Review/ Date:

□ CT: _____ □ MRI:_____

□ U/S: _____□ Other_____

Medical History: □ Pre-Transplant □ Post-Transplant

_____

_____

_____

Question: _____

_____

_____

Reviewed by:_____ Date:_____

Impression/Recommendation_____

_____

_____

_____

Cleared for transplant from surgery standpoint ☐ Yes ☐ No

Revised 11/9/2026