

Kidney/Pancreas Pre-Transplant Evaluation Screening

Name:		
DOB:	Age:	US Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No
Ph# _____	Alt # _____	
Nephrologist:	Height:	Weight: BMI:
Nephrology Group:	Evaluated by other center?	
Date of first Dialysis:	Where?	
Dialysis Center:		
Shift:	Do you use a wheelchair or other assistive devices?	
Previous Transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Assessment		
Cause of Kidney Disease:	History of	
Diabetes: Type : I <input type="checkbox"/> or II <input type="checkbox"/>	<ul style="list-style-type: none"> • Depression <input type="checkbox"/> Yes <input type="checkbox"/> No • Anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No • Other Mental Illness: 	
<ul style="list-style-type: none"> • Insulin <input type="checkbox"/> • Oral agent <input type="checkbox"/> • Age diagnosed with DM: 		
Prior kidney biopsy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had HepB Vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
<ul style="list-style-type: none"> • When/Where: 	Have you had Covid-19 Vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No	
High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Brand: Date(s):	
Blood Trans? <input type="checkbox"/> Yes <input type="checkbox"/> No When:	Family History	
Hx of Cancer: <input type="checkbox"/> Yes <input type="checkbox"/> No		
<ul style="list-style-type: none"> • Type: 		
Most Recent Colonoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No	Surgical History w/dates:	
<ul style="list-style-type: none"> • Date: • Dr/Facility: 		
Last Mammogram		
<ul style="list-style-type: none"> • Date: • Dr/Facility: 		
Last PAP Smear	Other pertinent Medical History	
<ul style="list-style-type: none"> • Date: • Dr/Facility: 		
History of positive TB Skin Test? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<ul style="list-style-type: none"> • TB treatment (when/where)? 		
History of heart disease/angina? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<ul style="list-style-type: none"> • Heart surgeries/procedures? <input type="checkbox"/> Yes <input type="checkbox"/> No • Dr/Facility: 	Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Yes	
History Lung Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	Meds (Continue on back if necessary)	
<ul style="list-style-type: none"> • Sleep Apnea <input type="checkbox"/> Home O2 use <input type="checkbox"/> • Smoker /vape/smokeless tobacco • How long/packs/day? 		
History of alcohol use/abuse?		
<ul style="list-style-type: none"> • How much/how long? 	Potential Living Donors?	
History of drug use/abuse?	If yes, who?	
<ul style="list-style-type: none"> • Name/route 		
Plan		
<input type="checkbox"/> Full Evaluation	Date:	
<input type="checkbox"/> Screening Evaluation to Include:	Coordinator Signature:	