

## Radiology Review – Kidney/Pancreas Transplant

Outside Imaging Facility: \_\_\_\_\_ Coordinator: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

MHD#: \_\_\_\_\_ DU# \_\_\_\_\_

DOB: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Films for Review/ Date:

CT: \_\_\_\_\_  MRI: \_\_\_\_\_

U/S: \_\_\_\_\_  Other \_\_\_\_\_

Medical History:  Pre-Transplant  Post-Transplant

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Question: \_\_\_\_\_

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Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Impression/Recommendation \_\_\_\_\_

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