**Oxford Pancreas Transplant Assessment**

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| **Demographics** | | | | | | | | | | | | | | | | | | | | |
| Name | | | | |  | | | | | | | | |  | | | | | | |
| DOB | | | | |  | | | | | | | | |
| Hospital No. | | | | |  | | | | | | | | |
| NHS No. | | | | |  | | | | | | | | |
| Address | | | | |  | | | | | | | | |
| Contact numbers | | | | |  | | | | | | | | |
| Age | | | | |  | | | | | | | | |
| Gender | | | | |  | | | | | | | | |
| Ethnicity | | | | |  | | | | | | | | |
| Employment | | | | |  | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Referral Details** | | | | | | | | | | | | | | | | | | | | |
| Date seen | | | | |  | | | | | | Clock start | | | | | |  | | | |
| Clinic | | | | |  | | | | | | Clock stop | | | | | |  | | | |
| Tx Surgeon | | | | |  | | | | | | Reason | | | | | |  | | | |
| Tx Coordinator | | | | |  | | | | | | Ref. Consultant | | | | | |  | | | |
| Local Coordinator | | | | |  | | | | | | Contact details | | | | | |  | | | |
| Organ(s) required | | | | |  | | | | | | Dialysis Status | | | | | |  | | | |
|  | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Transport Plan** | | | | | | | | | | | | | **GP Details** | | | | | | | |
| Own Transport | | | | Yes / No | | | | | | | | | Address | |  | | | | | |
| Hospital Transport Plan  Inward journey  Outward journey | | | | | |  | | | | | | |
| Pre-authorisation code | | | | | |  | | | | | | | Phone | |  | | | | | |
| Back Up? | | Yes / No | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Is there a LD Kidney option?** | | | | | | | | | Yes / No | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Clinical Basics** | | | | | | | | | | | | | | | | | | | | |
| Height  Weight(dry) | | |  | | | BMI |  | | | Hip/Waist ratio | |  | | | | BP  Pulse | |  | | |
| SF-36 questionnaire done – Y / N | | | | | | | | Hypoglycaemia questionnaire GOLD Score: | | | | | | | | | | | GCSI score : | |
|  | | | | | | | | | | | | | | | | | | |

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| **Referred for** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| **Diabetic and Renal History** | | | | | | | | | | | | | | | T1/T2, date diagnosis, DM complications (retinopathy/peripheral neuropathy/autonomic neuropathy/gastroparesis/BM control/hypo-awareness), eGFR, dialysis & start date, access, previous Tx, vascular access – lines/fistulae/PD | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No. of severe hypos in last 24 months = 3rd party help =  Paramedic =Hospital = | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Past Medical/Surgical History** | | | | | | | | | | | | | | | | | MI / Stent / CABG, PVD, DVT, malignancies, TB, previous infections, asthma, urological issues | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Drug History** | | | | | | meds, insulin/24hrs, allergies, anti-coagulation, recreational drugs, non-prescription,  Alert if on NOACS-Dabigatran,Rivaroxaban,Apixban .Consider if pregnancy advice needed re MMF | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| **Anaesthetic Assessment** | | | | | | | | | | | | | | exercise tolerance, ITU stays, OSA, airway issues, dental status, previous vascular access, last CXR | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Social History** | | | | | | | smoking history (pack yrs), alcohol, home situation, psychiatric history, post Tx support, ref. social services?, care package | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Check List** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PAP smear date: Pregnancies& Counselling re MMF: Mammogram  Blood Transfusions: Y / N Date: Dentition:  VZV immunity: Y / N Female, <55yr & Rh NEG? – Y / N CXR date: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Patient Experience Seminar** – interested in attending upcoming seminar? | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Yes / No** | | | |
| Date to attend / date attended: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Clinical Examination** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **HS** **|\_\_\_\_\_\_| |\_\_\_\_\_\_|** | | | | | | | | | | | |  | | | | | | | | | |  | |  | |  | | |  | | |
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| **Plan and Investigations Required** | | | | | | | | | | | | | | | | | | MPS, other cardiac, CXR, carotid dopplers, abdo/pelvic duplex, psych ref., next appointment. | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date | |  | | | | | | | Assessing Surgeon | | | | | | |  | | | | | | | Assessing Coordinator | | | |  | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Cardiac Investigation Outcomes** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type of scan | | |  | | | | | | | Date | | |  | | | | | | Centre | |  | | | | | | | | | | |
| Report details: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type of scan | | |  | | | | | | | Date | | |  | | | | | | Centre | |  | | | | | | | | | | |
| Report details: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Cardiology MDT Summary** if applicable | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date** |  | | | | **Present** | | | | | |  | | | | | | | | | | | | | | | | | | | | |
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| **Listing MDT Summary & Transplant Plan** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date** |  | | | | **Present** | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| **Issues discussed:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Outcomes/Actions:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Consultant sign off:** | | | |  | | | | | | | | | | | | | | | | | | | | | CRF at listing | | | | |  | |

**Oxford Pancreas Transplant Document: Continuation Notes**

|  |  |
| --- | --- |
| Name |  |
| DOB |  |
| Hospital No. |  |
| NHS No. |  |

|  |  |
| --- | --- |
| **Date** | **Progress** |
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| --- | --- |
| cRF when listed: |  |