

Medical Review Board Statement

Dialysis/Transplant Information Exchange

The Medical Review Board of ESRD Network 18 recommends implementation of the following steps to improve communication between dialysis facilities and transplant centers to facilitate the transplant referral process.

From dialysis units (nephrologists) to transplant programs

1. With the initial referral to the transplant program, all pertinent clinical information that has already been done. i.e. H & P, X-rays, laboratory, etc.
2. Notification to the transplant program of any of the following changes of those patients on the waiting list:
 - a. Patient moved out of area
 - b. Patient's death
 - c. Any major change of physical condition. i.e. CVA or major surgery.
 - d. Insurance changes.
 - e. Any significant psychosocial changes.
3. Early referral to transplant program with any transplant organ dysfunction.

From transplant program to dialysis unit (nephrologists)

1. Regular reports on the status of the patient with the transplant program. i.e. finished consultation phase, transplant work-up phase, listed (active vs. in-active), not a candidate, transplanted.
2. Results of clinical testing from the transplant work-up. i.e. cardiac, G.I., neurological testing, laboratory results, psychosocial evaluation, etc.
3. Comprehensive report after the transplant before the patient returns to the nephrologists.

Note: Since every transplant center and dialysis unit are unique, one point of needed clarification is who is primarily responsible for ordering and obtaining the results of the transplant work-up? Is it the transplant program, dialysis unit, nephrologists, or a combination of these? The Medical Review Board suggests that your facility communicates with your corresponding transplant center(s) regarding it and complete forms and return them to the requesting party in a timely manner.

Below are the examples of communication elements between dialysis facilities and transplant centers to maintain accurate/updated status of the patient on the transplant wait list.

Transplant Control Form

- Patient is new to dialysis. Date of first dialysis treatment: _____
 Patient is not a transplant candidate due to the following medical conditions: _____

Signature: _____, MD Date: _____

- Patient has been evaluated, but found not eligible for a transplant due to the following medical condition: _____

Signature: _____, MD Date: _____

- Patient is not interested in this option at all.
 Patient is not interested in this option at this time.
 Patient would like to be evaluated for a transplant/referred to a transplant center. Date: _____
 • Transplant Center: _____ Phone: _____
 Patient is currently being evaluated for transplant at: _____ Date: _____
 Patient is currently being evaluated for transplant at: _____ Date: _____
 • Contact Person: _____ Phone: _____
 Patient is currently listed on a transplant waiting list(s) at: _____ Date: _____
 • Contact Person: _____ Phone: _____

Monthly Follow-Up

Month	Date	Comments	Initial
January			
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			

It is recommended that transplant assessment/education start upon admission and revisited 90 days after the start of dialysis and monthly/quarterly/annually thereafter per the facility's protocol.

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Transplant Center: _____
Annual Anniversary Review

Date: _____

Re: Patient Name: _____

Date of Birth: _____

Dear Dr./Dialysis Center,

We would appreciate a brief medical update on your patient who is currently on the waiting list for a transplant at the University of California, Irvine Medical Center Division of Transplantation. Updated medical information will help ensure a safe and successful transplant experience. During the past year, has your patient had:

- | | | | |
|-------------------------------|-----------------------------|------------------------------|-------|
| Patient's current dry weight | <input type="checkbox"/> NO | <input type="checkbox"/> YES | _____ |
| Chronic infection of any type | <input type="checkbox"/> NO | <input type="checkbox"/> YES | _____ |
| Cancer diagnosis | <input type="checkbox"/> NO | <input type="checkbox"/> YES | _____ |
| Cardiac issues | <input type="checkbox"/> NO | <input type="checkbox"/> YES | _____ |
| Stroke, TIA or seizure | <input type="checkbox"/> NO | <input type="checkbox"/> YES | _____ |
| Serious hospitalization | <input type="checkbox"/> NO | <input type="checkbox"/> YES | _____ |
| Dialysis access problems | <input type="checkbox"/> NO | <input type="checkbox"/> YES | _____ |
| Change in dialysis center | <input type="checkbox"/> NO | <input type="checkbox"/> YES | _____ |
| Change in insurance | <input type="checkbox"/> NO | <input type="checkbox"/> YES | _____ |

Serious mental, emotional or compliance problems NO YES _____

Wait changes > 10% over last year NO YES _____

Gain/loss Intentional/unintentional

BMI: _____

Dialysis Representative Signature: _____

Nephrologist Signature: _____

Date completed: _____

Is there any reason that this patient should not be active on the transplant wait list?

NO YES

Why? _____

The completion of this form is very much appreciated.
This form may be faxed to (XXX)XXX-XXXX

Patient Barriers to Transplant Evaluation

This form is to be completed by eligible patients *who decided not to proceed* with a transplant evaluation.

Please answer the questions below to the best of your knowledge. Please note that this survey is anonymous and if you don't feel comfortable answering any of these questions, you may leave them blank.

1. Gender: Female Male

2. Age: 15-20 21-30 31-40 41-50 51-60
 61-70 71-80 >81

3. Residency Status: U.S. Resident NON U.S. Resident

4. Education: Grade 1-6 Grade 6-12 Some College
 College Graduate Masters

5. Race: (Check all that apply.)
 American Indian/Alaskan Native Black/African American
 Asian Native Hawaiian/Pacific Islander
 White Latino

6. Are you currently working? Yes No

7. What County do you live in?
 Imperial Inyo Kern Kings
 Los Angeles Orange Riverside
 San Bernardino San Diego San Luis Obispo
 Santa Barbara Tulare Ventura

8. What type of healthcare coverage do you have? (Check all that apply)
 Medi-Cal Emergency Medi-Cal Employer based coverage
 Medicare (Basic, HMO, PPO) Private Insurance
 None

9. Do you speak English? Yes No A Little
If No, what language do you speak? _____
Do you have someone who can translate for you? Yes No

10. Were you informed about transplantation as a treatment choice?

- Yes (Proceed to question 11) No (See below)

- If you *were not* informed about transplantation as a choice, would you be interested in finding out more information?

- Yes No

11. If you have *not been evaluated* for a transplant what is the reason for not proceeding with the process?

- Was not aware I had treatment choices
- Need more information. (I don't understand what transplantation means for me.)
- I'm not interested
- Do you consider transplant too expensive?
- Yes: Please explain: _____
- No
- Unable to attend all required evaluation appointments due to:
- Unable to take time off work
- No transportation
- No family support
- Religious beliefs
- Physician feels I'm not a candidate
- I have other medical conditions that disqualified me for a transplant
- Describe: _____
- Other: Please state: _____

Barreras Camino a Ser Evaluado Para Trasplantes

En Español

Este formulario debe ser llenado por pacientes elegibles para trasplantes que decidieron no proceder con la evaluación.

Por favor conteste las siguientes preguntas. Nota: este cuestionario es anónimo y si no se siente cómodo contestando las preguntas, puede dejarlas en blanco.

1. Sexo: Femenino Masculino

2. Edad: 15-20 21-30 31-40 41-50 51-60
 61-70 71-80 >81

3. Estatus Legal: Residente Legal No Soy Residente Legal

4. Educación: Grado 1-6 Grado 6-12 Algo de Universidad
 Grado Universitario Master

5. Raza: (Marque todas las que aplican)
 Indo-Americana/Nativa de Alaska Negra/Afro-Americana
 Asiática Nativa de Hawaii/Pacífico-Isleña
 Blanca Latina

6. ¿Está trabajando? Si No

7. ¿En qué condado vive?
 Imperial Inyo Kern Kings
 Los Angeles Orange Riverside
 San Bernardino San Diego San Luis Obispo
 Santa Barbara Tulare Ventura

8. ¿Tiene seguro médico? Si (siga a la pregunta 9) No

9. Si tiene seguro médico, ¿qué tipo de seguro médico tiene? (Marque todos los que aplican)
 Medi-Cal Medi-Cal de Emergencias Seguro por empleador
 Medicare (Básico, HMO, PPO) Seguro Privado

10. ¿Habla inglés? Si No Poco
En caso de No, ¿ Tiene alguien que puede traducirle?
 Si No

MRB Statements & Resources- Transplant Referral

11. ¿Estaba informado(a) sobre el trasplante como una opción de tratamiento?

- Si (siga a la pregunta 12) No (lea abajo)

Si no fue informado(a) sobre el trasplante como una opción, ¿Le interesa tener más información?

- Si No

12. Si *no ha sido evaluado (a)* para un trasplante, ¿porqué no ha seguido con el proceso?

- No sabía que tenía opciones de tratamiento
 Necesito más información. (No sé que significa un trasplante para mí)
 No me interesa
 ¿Considera que el trasplante es demasiado caro?
 Si: Por favor explique: _____
 No
 No pude asistir a todas las citas requeridas para la evaluación porque:
 No puedo tomar tiempo libre de mi trabajo
 No tengo medio de transporte
 No tengo apoyo familiar
 Creencia de religión
 El médico opina que no soy candidato(a)
 Padezco de otras condiciones médicas que me descalifican para el trasplante
Describe: _____
 Otra: Por favor explique: _____