APPENDIX 1

RENAL RECIPIENT ASSESSMENT CHECKLIST

The referring nephrologist should complete the assessment sheet and send a copy to the transplant assessment clinic with a referral letter (See page 4).

Please read in conjunction with referral letter

Patient ID Sticker	Date: Renal Consultant: Referring doctor: Referring Centre:

On dialysis Y / N

Date started RRT:

Modality HD / PD

If not on dialysis, what is estimated date of first RRT ?

Primary Renal Disease:

Recurrence risk: Low / High

Weight: Height: BMI:

Allergies: Family history:

Previous Transplant History: Date of Transplant: Reason for Failure: Date of Failure

Cardiac evaluation:

Does the patient have:
Angina ? Y / N Details if Y:

MI ? Y / N Details if Y:

Heart failure ? Y / N Details if Y:

Current or ex-smoker ? Y / N Details if Y:

ECG done? Y / N If Y: Normal / Abnormal

An echocardiogram should be performed in those with a significant cardiac history, severe hypertension, heart failure or suspected valvular disease:

Has an echocardiogram been performed ? Y / N
If Y: Normal / Abnormal

Details if abnormal:

Is further cardiovascular investigation required ? Y / N
Details if Y:

Cerebrovascular evaluation:

Previous or current history of stroke or TIA ? Y / N
Details if Y:

Is further investigation required? Y / N
Details if Y:

Peripheral vascular evaluation:

Previous or current history, or signs of peripheral vascular disease ? Y / N
Details if Y:

Is further vascular investigation required ? Y / N
Details if Y:

Urological evaluation:

Previous history of urological disease ? Y / N
Details if Y:

Is urinalysis normal ? Y / N
If N is this explained by primary renal disease ? Y / N

Is there a history of recurrent UTIs ? Y / N
Details if Y:

Current MSU done ? Y / N / anuric
Sterile ? Y / N

Has renal tract ultrasound been done
within last 3 years ? Y / N
Details:

Is further urological investigation required ? Y / N
Details:

Respiratory evaluation:

Does the patient have chronic lung disease ? Y / N
Details if Y:

Does the patient have unexplained dyspnoea or exercise limitation that is not explained by current renal condition? Y /
Details if Y:

Is there a history of or concerns regards TB ? Y / N
Details if Y:

Does TB prophylaxis need to be given at time of transplant ? Y / N

Chest x-ray done ? Y / N
If Y: Normal / Abnormal

Is further respiratory investigation required ? Y / N
Details if Y:

Malignancy risk:

Previous history of malignancy ? Y / N
Details if Y:

Investigations:	Done:	Not done:	Not required:	Normal:	Abormal:	Further action required:
Mammogram (all ♀ > 40 years)						
PSA (all ♂ > 50 years)						
FOB, CEA or colonoscopy (all > 50 years)						
Plasma protein electrophoresis (all > 60 years)						
Cervical smear test where appropriate:						
Other:						

Viral infection:

Is there is evidence of infection with: Hepatitis B or C ? Y / N

HIV ? Y / N

If Y to any of the above, has expert opinion been obtained (hepatology / infectious diseases) ? Y / N

Remember: need to consider interaction between anti-retroviral agents and tacrolimus ! Are alternative agents required ?

Immunity to infection:

Is there evidence of immunity to: CMV Y / N
If N, risks discussed ?

EBV Y / N
If N, risks discussed ?

VZV Y / N

If N, risks discussed ?

If N, immunisation arranged ?

Thrombosis risk:

Is there a history of recurrent / unexplained DVT or other clotting abnormality (graft / fistula loss) ? Y / N

Is there a history of recurrent miscarriage if ♀ ? Y / N

If Y to either, has thrombophilia screen been done ? Y / N
If Y: Normal / Abnormal

Is a haematology opinion required ? Y / N

Psychosocial state:

Is there current or previous history of:
significant psychiatric disease ? Y / N

substance abuse (including alcohol) ? Y / N

non-compliance ? Y / N

Is a psychiatric opinion required ? Y / N

Miscellaneous:

Good healthy dentition ? Y / N
If N, action required ?

Investigation checklist for transplant co-ordinators at time of referral:

Test	Done ?	Date	Normal ?	Abnormal ?	Action required
FBC					
LFTs					
PTH					
Blood group (twice)					
Tissue Typing					
Anti-HLA Abs					
CXR					
ECG					
Renal Ultrasound					
MSU					
Urinalysis					
HepBsAg					
HepC Ab					
HIV Ab					
CMV					
EBV					
VZV					

Outcome of assessment:

Are further investigations required ? Y / N
If N, can patient be listed ? Y / N

If Y, please complete the following:

Test required:	Requested ?	Date requested:	Result seen ?	Normal / Abnormal ?	Action required:

If an outstanding investigation has not been requested, who is responsible for ordering the request ?

Has this instruction been conveyed to the requestor ? Y / N

Final outcome: _____

Date: _____

Signed: _____