**Pancreas Candidate Summary**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Kidney | [ ]  | Sequential | [ ]  | Alone | [ ]  | Islet | [ ]  |

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| **OSOTC Patient Number:** |       |

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| **PATIENT DEMOGRAPHICS** |
| **Initials:**       | **Birth Date:**       | **Height:**       |  **Weight:**       |  |
| **Gender:** M [ ]  F [ ]  | **ABO:** A [ ]  B [ ]  AB [ ]  O [ ]  | **Race:**       | **Transplant#:**       |  |

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| **PATIENT STATUS** |
| **MEDICAL DIAGNOSIS:**       |
| **GFR:**       | **Dialysis:** Yes [ ]  No [ ]  | **C-Peptide:**       | **Insulin:** Yes [ ]  No [ ]  |
| **MEDICAL HISTORY** (Please indicate co-morbidities, malignancy history, nutritional status, infection, etc.):      |

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| **LABORATORY DATA** |
| **Renal** | Patient | Lab Date | Normal Range |
| Bun |       |       |       |
| Creatinine |       |       |       |
| **Hepatic** | Patient | Lab Date | Normal Range |
| AST (SGOT) |       |       |       |
| ALT (SGPT |       |       |       |
| Alk Phos |       |       |       |
| Amylase |       |       |       |
| T Bili |       |       |       |
| PT |       |       |       |
| PTT |       |       |       |
| HBsAg |       |       |       |
| **Other** | Patient | Lab Date | Normal Range |
| WBC |       |       |       |
| Platelets |       |       |       |
| Albumin |       |       |       |
| Calcium |       |       |       |
| Sodium |       |       |       |
| Potassium |       |       |       |
| Chloride |       |       |       |
| CO2 |       |       |       |
| Glucose |       |       |       |
| Phosphorus |       |       |       |
| Cholesterol |       |       |       |
| Uric Acid |       |       |       |
| T Protein |       |       |       |
| LDH |       |       |       |
| HIV Screening |       |       |       |
| Anti HBC |       |       |       |
| Anti HBS |       |       |       |
| Anti HCV |       |       |       |
| Anti HBSAG |       |       |       |

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| **Psychosocial Evaluation/Quality of Life**(Support system, informed consent, attitude about transplant, aftercare, complications, etc.): |
|       |

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| **Ohio Medicaid Insurance**The Ohio Medicaid Required Information Form should be submitted along with this summary. |
| **Select Type:**  | Standard Medicaid [ ]   | Medicaid Managed Care Plan [ ]   |