

Name: _____
 MRN: _____
 Translator needed: _____

TODAY'S DATE: _____ REQUESTED BY: _____

TEST SCHEDULING REQUEST FORM

TRANSPLANT EVALUATION

Urgent (2 weeks) Routine (4 weeks)

Standard transplant evaluation:	<input type="checkbox"/> Complete	Local	Columbia
CXR/ <input type="checkbox"/> EKG Dx: Liver Transplant Eval. R/O: Cardiopulmonary disease		<input type="checkbox"/>	<input type="checkbox"/>
Abdominal MRI/CT Dx: Cirrhosis R/O: HCC		<input type="checkbox"/>	<input type="checkbox"/>
Endoscopy Dx: _____ R/O: varices		<input type="checkbox"/>	<input type="checkbox"/>
Colonoscopy (>50yrs) Dx: _____ R/O: polyps		<input type="checkbox"/>	<input type="checkbox"/>
Bubble Echo Dx: _____ R/O: Pulmonary Hypertension/HPS		<input type="checkbox"/>	<input type="checkbox"/>
Adenosine/dobutamine stress (>50yrs) Dx: _____ R/O: ischemia		<input type="checkbox"/>	<input type="checkbox"/>
ABG on room air/ <input type="checkbox"/> 100% oxygen Dx: _____ R/O: HPS		<input type="checkbox"/>	<input type="checkbox"/>
PFT's with DLCO Dx: _____ R/O: HPS		<input type="checkbox"/>	<input type="checkbox"/>
PPD (within last year)		<input type="checkbox"/>	<input type="checkbox"/>
Bone Density Scan		<input type="checkbox"/>	<input type="checkbox"/>
Mammogram/Pap Smear with HPV testing (all female pts.) R/O Cervical dysplasia		<input type="checkbox"/>	<input type="checkbox"/>

Psychiatric Evaluation _____
 Social Work Evaluation _____
 NP _____

Surgeon _____
 Radiologist _____

Nutritionist if indicated per nutrition screen _____
 Financial Coordinator _____

Additional Testing if >65 years or increased Cardiac risk factors

Carotid Dopplers _____
 Cardiology consult _____

Neurology consult Indication: Severe encephalopathy, CVA, carotid disease

Additional Testing if Cancer patients

Chest CT without contrast R/O metastasis _____
 Bone scan R/O metastasis _____

Interventional Radiology consultation Form sent _____

Oncologist _____

PET scan _____

Other Consults/Tests

Pulmonology consult Clinic or Pulm. Transplant Dx: _____ R/O: _____

RCP (Dr. Stevens) _____

Infectious Disease: all HIV patients Dx: _____ R/O _____

OTHER: Dx: _____ R/O _____

Pt. Preferences: Avoid _____ Prefer _____
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For all patients: ABO blood type and cross match, Hepatic Function Panel, Chem 7, CBC w/ diff, PT/PTT/INR, AFP, CMV, EBV, Varicella, RPR Hepatitis A total, HBsAb, sAg, cAb, HCV Ab, HIV For certain patients: Ca 19-9 (if patient has HCV RNA Q (all HCV patients), HBV DNA Q, HbeAg, HbeAb, HB Delta (All HbsAg + patients) PSA (men over 40 y) HIV viral T cell panel, toxo antibody, HSV I and II (all HIV patients)