



Pancreatic Islet Program Physician Referral Form

Patient Name: _____

DOB: _____

The Patient listed above has applied to the Pancreatic Islet cell Replacement Therapy Program at UChicago Medicine and has listed you as his/her physician currently managing diabetic care. Please complete this brief form and mail/fax directly to the Pancreatic Islet Cell Transplant Office, your collaboration will facilitate his/her application. If you do not feel this patient would make a good candidate for islet replacement therapy, please indicate so in your responses. Thank you for your time.

A. Does your patient have any of the following specific indications for transplant:

	Yes	No	If Yes, please describe
1. Hypoglycemic Unawareness			
2. Metabolic instability or lability			
3. Progressive early secondary complications			
4. Failure of injected insulin as judged by a physician			

B. Is this patient compliant and following the prescribed regimen? Yes No
 If no, please explain

C. Please describe the patient's current insulin requirements and frequency of blood glucose monitoring:

D. Please provide any additional comments:

E. Would you be willing to interact regularly with our staff to share clinical information, lab data, immunosuppressive regimens, etc. after your patient's pancreatic islet cell transplant? Yes No



AT THE FOREFRONT

UChicago Medicine

Transplant Institute
5841 S. Maryland Ave
Chicago, IL 60637
Phone: 773-702-2504
Fax: 773-926-0671

F. The following test results (completed within the last 6 months) are required for the patient to continue the evaluation process. Your collaborative efforts in completing these tests are appreciated. Please include copies of laboratory reports with this form.

Test	Date	Results
Fasting Serum C-peptide		
Hemoglobin A1C		
Serum Creatinine		
Fasting Serum Glucose		
Creatinine Clearance (as determined by 24 hour urine collection)		

Physician Signature: _____

Physician Name (please print): _____

Office Mailing Address:

Office phone: _____

Office Fax: _____

Thank you for your efforts. You may call 773-702-2504 with any questions.

Please send completed form with test results to:

Fax: 773-926-0671

Mail:

UChicago Medicine
Transplant Institute
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