REMINDER: Ask to consent for SKIN, THYMUS & BONE MARROW.
Ask for as much blood as we can get.

Date: _____

CASE REFERRAL FORM

Please complete for all referred cases

Call taken by_____

Accepted ◯ **Declined** ◯

Reason _____

OPO Information:

IIAM ◯ Y/N ◯ OPO _____

Coordinator name & Phone _____

Inclusion/Exclusion Criteria:

- T1D < 25 years of age
- AAb+ (2 or more & <30 YOA)
- T2D on Incretin therapy for AT LEAST 12 months (Byetta/Exenatide. Januvia/Sitagliptin)
- Pancreas or pancreas/kidney transplant recipient with history (any duration) of T1D
- Rare disease diagnosis

Demographics for all Cases

UNOS ID:	HLA A: ,	COD:
Location:	HLA B: ,	OR Time:
Age:	HLA DR: ,	Cold Time:
Race:	HLA DQ: ,	ETA:
Gender:	Serologies:	Shipping Job #:
BMI:	Comorbidities:	Consent Confirmed?

Suspected T1D

Duration:
Treatment Regimen: - Insulin? ◯ Y/N ◯ Type: - Oral meds? ◯ Y/N ◯ Type:
A1c:
Admit Glucose:
DKA: ◯ Y/N ◯

Suspected T2D

Duration:
Treatment Regimen: - Insulin? ◯ Y/N ◯ Type: - Oral meds? ◯ Y/N ◯ Type:
A1c:
Admit Glucose:
DKA: ◯ Y/N ◯

Other

What disease?
If pancreatic disease, what?
Duration:
Meds:

AAb+

GAD:
IA2:
ZnT8:
A1C:
Meds:

Transplant Patient

Pancreas: ◯ Y/N ◯
T1D: ◯ Y/N ◯
A1C:
Glucose:
Meds:

Other Notes:

Submit by Email