Allina Health

Re: Kidney Transplant Candidate

Dear Health Care Provider:

Your patient is undergoing evaluation for potential kidney transplant candidacy. As part of the evaluation, patients are required to have their routine health screens updated if they are not up to date. Included in these routine screens is a Pap and pelvic exam.

If a patient is approved for kidney transplant, she may be transplanted at any time when a donor becomes available. After transplant, she will be given high doses of induction immunosuppression and will remain on immunosuppression medication as long as the kidney is functioning. Although annual exams may deviate from current recommendations guidelines, we recommend an external visualization and pelvic exam annually in anticipation of immunosuppression.

Based on current guidelines, patient history, and potential for her to receive immunosuppression medication, please complete the following form with patient's last date of screening and your recommendations for follow-up testing. Once completed, please return to the Transplant Office at 612-863-5626.

If you have any questions, please do not hesitate to contact the Transplant Department at 612-863-5638.

Thank you for your assistance and cooperation.

Sincerely,

Abbott Northwestern Kidney Transplant Team

Allina Health

Please return to:

Patient Name:_____ DOB:_____

History of abnormal Pap/pelvic: Y / N. If yes, when and treatment:_____

Recent exam:

Date of last Pap:_____

Results of last Pap:_____

Date of HPV testing:_____

Results of HPV testing:_____

Date of last pelvic/external visualization:_____

Results of last pelvic / external visualization:_____

_____

Follow-up recommendations:

Recommended follow-up Pap:_____

Recommended follow-up pelvic /external visualization exam:_____

(Transplant program recommends annual external visualization / pelvic exam annually in anticipation of immunosuppression).

Recommended follow-up HPV testing:_____

Based on most current gynecologic exam is patient cleared for transplant / immunosuppression? YES NO

Clinic name:_____ Clinic Phone:_____

Provider name (printed)_____ MD, DO, NP, PA

Provider signature:_____ Date:_____