



200 Hawkins Drive, 5231 RCP  
Iowa City, IA 52242  
Client Services: 866-844-2522

## TRANSPLANT PANCREAS CLINICAL HISTORY

**Please FAX Clinical History form and Transport Pancreas Pathology Requisition to 866-844-2522 (Toll Free) before shipping.**

**PLEASE PRINT CLEARLY**

Referring Transplant Surgeon: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Referring Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

Patient's Last Name: \_\_\_\_\_

Patient's First Name: \_\_\_\_\_

Patient's DOB: \_\_\_\_\_

Date and type of transplant (e.g. specify if pancreas only, pancreas/kidney, bladder drained graft):  
\_\_\_\_\_

Presentation: \_\_\_\_\_

Clinical Diagnosis/History/Relevant Physical Examination Data:

Immunosuppressive Meds/levels:

Other Meds:

**LAB:**

Glycemia: \_\_\_\_mg/dL      Serum amylase: \_\_\_\_mg/dL      Serum lipase: \_\_\_\_mg/dL

Urinary amylase (for bladder drained grafts) \_\_\_\_\_

If Combined pancreas/ kidney transplant: BUN.: \_\_\_\_mg/dL Creat.: \_\_\_\_mg/dL

Imaging results (? USG; ? CT; ? Doppler/vascular flow studies; ? Other): \_\_\_\_\_