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| --- |
| REQUEST DATE– (Y/M/D)  |

 **PATIENT INFORMATION**

|  |  |  |
| --- | --- | --- |
| CTR ID | PERSONAL HEALTH NUMBER | DOB – (Y/M/D)(­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_) |
| cPRA VALUE  | Dialysis Start Date (­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_) | BLOOD TYPE  |

 **SPONSORING PHYSICIAN INFORMATION**

|  |  |
| --- | --- |
| NAME OF SPONSORING PHYSICIAN | TRANSPLANT CENTRE |

 **Pre-requisites**

|  |  |
| --- | --- |
| Approved for and actively listed on the standard deceased donor list, applicable ABO Compatible lists and local  “O” list, by local transplant centre | [ ]  |
| Listed as Medically Urgent on the local deceased donor list | [ ]  |

 **CLINICAL DIAGNOSIS INFORMATION**

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| --- |
| MEDICAL RATIONALE FOR REQUEST – Select Applicable Reason(s) |
| [ ]  **Lack of Hemodialysis access**SELECT : [ ]  *No SUITABLE VESSELS* [ ]  *No vascular surgery availability* [ ]  *other (Please Specify in Comments)*Comments: |
| [ ]  **Lack of PD Access**Please choose:  [ ]  *Previously failed PD* [ ]  *Adhesions or other surgical contraindication* [ ]  *patient preference*  |
| [ ]  **Uremic Cardiomyopathy** SELECT: [ ]  *PD* [ ]  *Intermitent hd 4x/wk or less* [ ]  *daily HD* [ ]  *Heart CathETERIZATION Done (iF yes, Specify Result in Comments)*Comments: |
| [ ]  **Other Conditions** – Provide Details: |

|  |  |
| --- | --- |
| **How to fill out the Highly Sensitized Kidney Patient Medical Urgency (2MU) Data COLLECTION Form** |  |
|  |  |
| REQUEST DATE – **Please ensure that the form is dated.** | 🞏 |
| patient information – **Please ensure that this section is filled out in full, as it allows us to identify the recipient in question.** | 🞏 |
| sponsoring physician information – **Please ensure that this section is filled out in full.** | 🞏 |
| clinical diagnosis information – **A clinical diagnosis is required, with comments indicating the reason for the request for a medically urgent status.** | 🞏 |
| form submission – **Fax or email this form to the following coordinates:** Fax **613-260-4090** Email**transplantregistry@blood.ca** |  |
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