

Willing-to-Cross (WTC) Requisition Form

Hospital Site & Program

- VGH SPH BCCH Other:
 Kidney Pancreas Islets Heart Lung Liver Other:

Transplant Patient Diagnosis:

Autoimmune Disease Present in the Transplant Patient?

- Yes
 No

Is the transplant patient on immunosuppressive or biologic therapy?

- Yes No

List therapies:

Transplant Physician: _____

MSP: _____

Primary Nephrologist: _____

MSP: _____

Coordinator: _____

Phone: _____

Fax: _____

RECIPIENT

Name: _____ SURNAME

_____ FIRST

Date of Birth: _____ DD-MMM-YYYY

Sex: M F

PHN: _____

BCT ID _____

KPD# _____

CTR# _____

RECIPIENT CLINICAL HISTORY

Dialysis Status _____	Start Date: _____	Previous Transplant(s)
# Pregnancies _____	Date(s): _____	Organ(s): _____
# Transfusions _____	Date of Last: _____	Donor(s): _____
Infections _____	Date of Last: _____	Date(s): _____

TEST REQUEST

Request for immunology assessment for the *National Willing-to-Cross (WTC) Program

*To be eligible into the National WTC Program, patient's unadjusted cPRA needs to be $\geq 99.0\%$ and adjusted cPRA needs to be $\geq 94.5\%$

Patient cPRA (unadjusted) _____

Date of request _____

Please email (immsot@vch.ca) or fax (604-875-3072) completed form to Vancouver General Hospital Immunology Lab.

Comments: _____