Duke Pediatric Kidney Transplant Program

Overview
We offer comprehensive evaluation and care to your pediatric and adolescent patients with kidney disease. Our experienced pediatric team works with you and other Duke specialists to diagnose and manage kidney disease and related conditions in children, including, but not limited to:

- Autoimmune disease
- Congenital kidney disease
- Inherited kidney disease
- Neurogenic bladder
- Nephrotic syndrome and focal segmental glomerulosclerosis
- Obstructive uropathy
- Issues from prior transplant with high antibody titers

Why Refer to Duke
We offer specialized care that is not available with other pediatric transplant programs, including:

- Expertise in congenital kidney conditions
- Paired donor kidney exchange
- Access to innovative clinical trials
- Early referral options with a focus on pre-emptive transplant
- Multi-organ transplant

Patient Survival Rates*
Better than U.S. Average

![Patient Survival Rates Graph]

* Data from srtr.org as of 7/6/23 for pediatric (<18) survival with functioning graft

When to Refer to Duke
Refer your patients when they:

- Develop kidney disease complications that appear to jeopardize their ability to function normally
- Have an eGFR <30 ml/min/1.73 m2
- Signs and symptoms include:
  - Failure to thrive
  - Development of swelling, lethargy, uncontrolled hypertension, and electrolyte abnormalities
  - Decreased quality of life, as indicated by fatigue, poor school performance, behavioral changes, or uremia
Your Patients Will Have Access To:

**Pediatric Kidney Transplant Specialists**

Our pediatric nephrologists and surgeons have special expertise in kidney transplant and offer:

- Kidney transplants for infants, small children, and adolescents
- Collaborative care with leaders in pediatric urology for complex bladder reconstructive surgery
- Steroid-free and calcineurin-free medication regimens that offer excellent long-term kidney function and allograft survival
- Monitoring for immunosuppression that is tailored for each specific patient
- Excellent outcomes in combined multi-organ transplants: simultaneous transplantation of the kidney and the liver, lung, heart, small bowel, and/or pancreas

**Clinical Trials**

We screen every patient for clinical trial eligibility to give your patients access to novel therapies.

**Qualified Donors**

We offer deceased and living-donor kidney transplantation and participate in national registries for benchmarking quality.

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**Our Care Team Members**

**Pediatric Transplant Coordinator**
Catherine Thomas, RN, BSN

**Nutritionist**
Bronwyn Cortez, RD

**Pediatric Nephrologists**
Eileen Tsai Chambers, MD  
*Medical Director, Pediatric Kidney Transplant*
Annabelle Chua, MD  
Rasheed Gbadegesin, MD  
Reeti Kumar, MD  
Shashi Nagaraj, MD  
Candice Sheldon, MD

**Pediatric Surgeons**
Allan Kirk, MD, PhD  
*Chair, Department of Surgery*
Debra Sudan, MD  
*Surgical Director, Abdominal Transplant Surgery*
Deepak Vikraman, MD  
*Surgical Director, Pediatric Abdominal Transplant*
Andrew Barbas, MD  
Bradley Collins, MD  
Stuart Knechtle, MD  
Lisa McElroy, MD  
Kadilyala Ravindra, MBBS  
Aparna S. Rege, MBBS

**Pediatric Urologists**
Todd Purves, MD, PhD  
Jonathan Routh, MD, MPH  
John Wiener, MD

**Social Worker**
Carrie King, LCSW

**Location**

Duke Children’s Hospital and Health Center  
2301 Erwin Rd.  
Durham, NC 27710

Phone  919-613-7777  
Fax  919-668-3897

**Pediatric Referral Coordinator**
919-681-2679

**On-call Physician**
919-684-8111

Find the most up-to-date list of providers at DukeHealth.org/Transplant
Duke Pediatric Kidney Transplant Referral Form

Please fax the completed referral form to 919-668-3897 or use electronic referral through Epic / MedLink. Once received, a scheduler will contact your patient to schedule an appointment. We appreciate your referral.

Patient Demographic Information

Name: ____________________________  Child’s Nickname: ____________________________
Address: __________________________
City: ____________________________  State: ____________________________  Zip: ____________________________
Social Security Number: ____________________________
Date of Birth: ____________________________  Gender: ____________________________  Race: ____________________________
Home Phone: ____________________________
Parent/Guardian Name: ____________________________
Parent/Guardian Phone: ____________________________
Emergency Contact: ____________________________
Phone: ____________________________  Relationship: ____________________________

Physician Information

Referring Physician: ____________________________
Practice/Group Name: ____________________________
Address: ____________________________
City: ____________________________  State: ____________________________  Zip: ____________________________
Phone: ____________________________
Fax: ____________________________
E-mail: ____________________________

Primary Care Physician: ____________________________
Practice/Group Name: ____________________________
Address: ____________________________
City: ____________________________  State: ____________________________  Zip: ____________________________
Phone: ____________________________
Fax: ____________________________
E-mail: ____________________________

Name of Person Completing This Form: ____________________________

Primary Insurance Information (attach copy of both sides of card)

Company: ____________________________
Policy ID: ____________________________
Group Number: ____________________________
Policyholder’s Name: ____________________________
Policyholder’s DOB: ____________________________
Insurance Phone Number: ____________________________
Referral or Pre-Cert Number: ____________________________
Behavioral Health Insurance? Y N
Company: ____________________________
Policy ID: ____________________________

Secondary Insurance Information (attach copy of both sides of card)

Company: ____________________________
Policy ID: ____________________________
Group Number: ____________________________
Policyholder’s Name: ____________________________
Policyholder’s DOB: ____________________________
Insurance Phone Number: ____________________________
Referral or Pre-Cert Number: ____________________________

Patient General Clinical Information

Seen at Duke University Hospital? Yes No
If yes, date of last visit: ____________________________
Patient Height: ____________________________  Patient Weight: ____________________________
Duke Medical Record Number: ____________________________

Clinical Information Requested to Schedule Appointment

1. Most recent clinical summary and current medications, immunization record, treatment plans, and past medical history or typed consult letter, including patient’s clinical summary and pertinent medical history
2. Lab results within 60 days, including renal function panel, calcium, magnesium, phosphorus, PTH, and CBC with differential
3. Renal imaging reports (Doppler and bladder ultrasound, CT, MRI, VCLUG, MAG3 or DMSA scan) within last 12 months
4. Procedural reports, including renal biopsy pathology
5. For patients with substance abuse history*: a. Summary of alcohol and/or substance abuse b. Date of abstinence c. Date rehabilitation counseling initiated d. Documentation of three random screens

* Items may be included in dictated summary or letter. Note: Patients with NC Medicaid primary insurance must meet eligibility in accordance to NC Medicaid. This must be completed by the referring MD. Please contact the referral transplant coordinator for testing requirement details.