Overview

Duke offers comprehensive evaluation and care for patients who need small bowel transplants. We offer isolated small bowel transplants and multi-organ transplants that include the small bowel, liver, and pancreas. The Duke Small Bowel Transplant Program is among the nation's highest volume programs and the only one in the region (North Carolina, South Carolina, Virginia, Kentucky, and Tennessee). Duke’s program is among fewer than 20 active programs in the U.S. and one of only a handful in the country serving both adult and pediatric patients.

To date, Duke surgeons have performed 36 small bowel transplants since the program was established in 2009.

Providers

ADULT HEPATOLOGY
Carl Berg, MD
Medical Director, Abdominal Transplant
M. Cristina Segovia, MD
Medical Director, Intestinal Transplant
Carla Brady, MD
Matthew Kappus, MD
Lindsay King, MD, MPH

PEDIATRIC HEPATOLOGY
Alisha Mavis, MD
Leon J. “Yul” Reinstein, MD

Surgery
Debra Sudan, MD
Surgical Director, Abdominal Transplant
Kadiyala Ravindra, MBBS
Deepak Vikraman, MD
Aparna Rege, MD

Contact
Phone 919-613-7777
Fax 919-681-7930
Toll Free 800-249-5864
On-Call Physician 919-684-8111
Adult Referral 919-684-3570, Julia Kyer, RN, MSN, CCTC
Pediatric Referral 919-668-2466, David Cousino, RN, BSN

dukehealth.org/transplant

Visit dukechildrens.org for more information on general pediatric gastroenterology, hepatology and nutrition.
Patient Demographic Information

Name: ____________________________ Veteran? Y N ____________________________
Address: ____________________________ Marital Status: ____________________________
City: ____________________________ State: ____________________________ Zip: ____________
Social Security Number: ____________________________ Date of Birth: ____________ Gender: M F Race: ____________________________
Home Phone: ____________________________ Work Phone: ____________________________
Cell Phone: ____________________________ E-mail: ____________________________
Emergency Contact: ____________________________ Phone: ____________________________ Relationship: ____________________________
Language: ____________________________ Interpreter? Y N ____________ Special Needs? Y N__
Employer: ____________________________

Physician Information

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

Has patient ever been seen at Duke University Hospital? (circle) No Yes If yes, date of last visit: ____________
Duke History Number: ____________ Height: ____________ Weight: ____________ Date: ____________
Smoking Cessation Date: ____________

Clinical Information Requested to Schedule Appointment

1. Most recent clinical summary and current medications, 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 total bilirubin, prothrombin time with INR, and chemistry panel including creatinine and sodium.
3. Abdominal imaging reports (Doppler ultrasound, CT, MRI) within last 12 months
4. Procedural reports including liver biopsy pathology, endoscopy, or colonoscopy most recent completed, if available
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 with NC Medicaid. This must be completed by the referring MD. Please contact the referral transplant coordinator for testing requirement details.