REFERRAL TO THE VMC 2019

Principle

Aim – track only to detect significant deterioration in renal fx or albuminuria to initiate F2F review with nephrologist

Patient Groups

There are two groups of patients we track those

1. KFRE >3% at **5yr** risk **BUT** less than 20% at **2yr**
2. KFRE**<3% at 5yr** risk transitioning back to GP if not happy to discharge immediately – these pts will be discharged to GP after 2 years of stable results (yearly)

Inclusion

1. Stable eGFR >15 and KFRE 5 yr risk >3% but <20% 2 yr risk plus stable macro albuminuria
2. Will only track/check eGFR and albuminuria annually
3. Additional tracking by GP / nephrologist

Exclusion

1. Monitoring of BP control or if a patient requires pathology tracking more frequently e.g. 6 monthly
2. eGFR<20 or KFRE >20% 2 year risk. These patients should be considered for PDEC
3. Patients having F:F f/u with a nephrologist

Referral Process

1. Ensure clinic letter is cc'ed to CKD CNC
2. Letter must include eGFR and ACR
3. Reference made to GP that the patient will be tracked via our VMC service
4. Provide patient with yearly lab form so results can be tracked (x2)

KFRE (*Kidney Failure Risk Equation* Score) calculated via http://kidneyfailurerisk.com/ to predict risk of developing renal failure i.e. needing dialysis or renal supportive care

25 Sep. 19