Trillium
Gift of Life
Network

ADULT HEART TRANSPLANTATION REFERRAL FORM

Referral Criteria for Heart Transplantation:

1) **Advanced Heart Failure:** Referral for heart transplantation should be considered for patients with advanced heart failure failing optimal medical and surgical (if appropriate) therapy. Such patients would have one or more of the following:
    - Late-stage heart failure due to any cause- AHA stage D
    - Patients who have significant cardiac dysfunction with marked symptoms of dyspnea, fatigue end-organ hypoperfusion at rest or with minimal exertion despite maximal medical therapy and/or surgical therapy
    - Refractory symptoms requiring specialized interventions to manage symptoms or prolong life.

2) **Anticipated Survival:** Referral for heart transplantation should be considered for patients with poor anticipated survival without a transplant.

3) **Quality of Life:** Referral for heart transplantation should be considered for patients who would experience an unacceptable quality of life without a transplant.

4) **Arrhythmias:** Referral for heart transplantation should be considered for patients who have refractory life-threatening arrhythmias despite optimal medication, surgical, and device therapy.

5) **Heart Disease:** Referral for heart transplantation should be considered for patients with complex congenital heart disease with failed surgical palliation or who are not amenable to surgical palliation at acceptable risk.

6) **Angina:** Referral for heart transplantation should be considered for patients with refractory angina not amenable to further revascularization.

To refer a candidate for heart transplantation, complete this form and attach all applicable documents.

Please indicate if your patient needs an URGENT or STANDARD assessment.

Submit the completed form, including all applicable documents to the appropriate transplant centre listed below:

Toronto General Hospital
Heart Function Clinic
Norman Urquhart Building, 5th Floor
585 University Ave.
Toronto, Ontario M5G 2N2
Fax: 416 340 4134

London Health Sciences Centre
Multi-Organ Transplant Program
339 Windermere Road
London, Ontario, N6A 5A5
Fax: 519 663 3858

University of Ottawa Heart Institute
Heart Transplant Program
40 Ruskin Street
Ottawa, Ontario K1Y 4W7
Fax: 613 761 4327

The completion of this form will expedite your patient's investigations and subsequent consideration for transplantation. Thank you for your cooperation in providing this material.

Ontario

Trillium Gift of Life Network

ADULT HEART TRANSPLANTATION REFERRAL FORM

Referral Type: ☐ **URGENT** ☐ **STANDARD**

Referring MD: ______________________________ **Contact #:** ____________________

Referring Centre: ____________________________ **Postal Code:** __________

Referral Form submitted to: __________________ **Date Submitted:** _______ **Date Received:** _______

Patient Demographic Information

Patient Name: ______________________________ **Health Card #:** ________________________

Date of Birth: ______________________________ **Sex:** ☐ Male ☐ Female ☐ Unknown

Address/City: ____ **Postal Code:** ___________

Language Spoken: __________________________

Patient Cardiac Information

Patient ABO (attach report): ___________________ **Height:** _____ **Weight:** ______

Diagnosis: ______________________________ **New Referral?** ☐ Yes ☐ No (re-transplant)

Baseline Characteristics:

EF ____ % / grade ____

NYHA Class: ☐1 ☐2 ☐3 ☐4

BP: ______

QRS > 120 ms: ☐Yes ☐No

Devices: ☐Yes ☐No

Biv Pacer: ☐Yes ☐No

Biv AICD: ☐Yes ☐No

AICD: ☐Yes ☐No

Laboratory Data:

Hb: __________________ Uric Acid: _______________ Na: ________________

% Lymphocytes: ________ Total Cholesterol: _________ Creatinine: ____________

NT-proBNP (optional): ____________

Medications:

Lasix _____mg (☐od ☐bid ☐tid)

Metalozone _____mg (☐od ☐bid)

HCTZ ______mg od

ACEI: ☐Yes ☐No

Beta-blocker: ☐Yes ☐No

ARB: ☐Yes ☐No

Allopurinol: ☐Yes ☐No

Statin: ☐Yes ☐No

Aldosterone blocker: ☐Yes ☐No

Lab Results

Please attach the copies of the following reports, <u>WHERE APPLICABLE:</u>

☐2D echocardiogram ☐Abnominal Ultrasound ☐Angiogram and CD

☐Bone Density Scan ☐CT Scan of Chest ☐Hemodynamic Monitoring

☐Blood Test Results ☐Heart Stress Tests ☐ECG

☐Chest x-ray ☐Urine Tests

Trillium Gift of Life Network

ADULT HEART TRANSPLANTATION REFERRAL FORM

PAST MEDICAL HISTORY

History of cancer:

☐No ☐Yes, please explain: ______________________________

History of peripheral vascular disease (ie., carotid, AAA, PVD):

☐No ☐Yes, please explain: ______________________________

Past surgeries:

☐No ☐Yes, please explain: ______________________________

History of psychiatric conditions (ie., social support, current substance abuse):

☐No ☐Yes, please explain: ______________________________

History of neurological conditions (ie., stroke and associated deficits):

☐No ☐Yes, please explain: ______________________________

COPD or lung related problems:

☐No ☐Yes, please explain: ______________________________

Please include any past medical history that may be relevant to patient assessment:

REFERRING CARDIOLOGIST

Patient Referral Type: ☐ Outpatient ☐ Inpatient

☐ **Referral letter attached**

Name: ______________________ **Phone #:** ______________

Signature: ______________________ **Date:** ______________

To be completed by Transplant Cardiologist:

Urgency: ☐ High ☐ Average

Name: ______________ **Signature:**______________ **Date Received :** ______________