Trillium Gift of Life Network

KIDNEY TRANSPLANT REFERRAL FORM

Referral Criteria for Kidney Transplantation: Patients should be referred for evaluation by the transplant program once renal replacement therapy is expected to be required within the next 12 months. Patients already requiring dialysis support should be referred for transplant evaluation as soon as their medical condition stabilizes. The criteria identified below are the agreed upon conditions for which a patient should be referred for a kidney transplant assessment:

1) Chronic Kidney Disease: Referral for kidney transplantation should be considered for patients with progressive Chronic Kidney Disease.
2) End Stage Renal Disease (ESRD): Referral for kidney transplantation should also be considered for patients with End Stage Renal Disease (ESRD).

To refer a candidate for kidney or kidney/pancreas transplantation complete this form and attach all applicable documents.

For patients seeking a living donor kidney transplant, please refer the patient to the transplant centre of your choice. For adult deceased donor kidney transplant, please refer the patient to the appropriate centre by consulting the table below:

Transplant Centre	LHIN Referral Catchment Area
London Health Sciences Centre	▪ Erie St. Clair ▪ South West ▪ North East (Sudbury & Sault St. Marie) ▪ Waterloo Wellington ▪ North West
St. Joseph's Healthcare Hamilton	▪ Hamilton Niagara Haldimand Brant ▪ Mississauga Halton
University Health Network *or* St. Michael's Hospital	▪ Central West ▪ Toronto Central ▪ Central ▪ Central East ▪ North Simcoe Muskoka ▪ North East (North Bay)
Kingston General Hospital	▪ South East
The Ottawa Hospital	▪ Champlain

Submit the completed form to the appropriate transplant centre listed below:

University Health Network
Transplant Assessment Center c/o NCSB 12C-1217
Toronto General Hospital
585 University Ave.
Toronto, Ontario M5G 2N2
Fax (Kidney): 416-340-5209
Fax (Pancreas): 416-340-4340
Email: Kidneytransplantreferral@uhn.ca

St. Michael's Hospital
Kidney Transplant Program
61 Queen Street East, 9th Floor
Toronto, Ontario M5C 2T2
Fax: 416-867-3723
Email: kidneytransplantreferrals@smh.ca

St. Joseph's Healthcare Hamilton
Department of the Renal Transplant Program and Clinics
Level 0 Marian Wing
50 Charlton Ave E.
Hamilton, Ontario L8N 4A6
Fax: 905-521-6189

The Hospital for Sick Children
Renal Transplant Program
555 University Avenue, room 6428
Toronto, Ontario M5G 1X8
Fax: 416-813-5541

Kingston General Hospital
Renal Transplant Office, Burr Room 21.2.025
76 Stuart Street
Kingston, Ontario K7L 2V7
Fax:613-548-1394

London Health Sciences Centre
Renal Recipient Transplant Office, UH Campus
339 Windermere Rd.
London, Ontario N6A 5A5
Fax: 519-663-3858

The Ottawa Hospital
Riverside Campus of The Ottawa Hospital,
Renal Transplant Office, Rm 518
1967 Riverside Dr.
Ottawa, Ontario K1H 7W9
Fax: 613-738-8489

Ontario

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REFERRAL INFORMATION

Referring MD: _____ **Date Received:** _____

Referring Centre Contact Name: _____ **Contact #:** _____

Referring Centre: _____ **Postal Code:** _____

Referral Form submitted to: _____ **Date submitted:** _____

☐ **Medically Urgent Referral** if yes, please indicate reason:

- ☐ Lack of vascular access
- ☐ Uremic complications in spite of maximal dialysis prescription
- ☐ Uremic cardiomyopathy
- ☐ Uremic Pericarditis
- ☐ Severe Uremic Neuropathy
- ☐ Other:_____

PATIENT INFORMATION

Patient Name: _____ **Health Card #:** _____

Date of Birth: mm / dd / yyyy **Race:** _____ **Sex:** ☐ Male ☐ Female

Address: _____ **Postal Code:** _____

Phone #: _____ **Language Spoken:** _____

GP Name: _____ **GP Contact:** _____

CLINICAL INFORMATION

ABO: ____ **RH Factor:** ☐ Positive ☐ Negative **Height (m):** ___ **Weight (kg):** ____ **BMI:** ____

Diagnosis: _____ **eGFR:** _____ ml/min/1.73m^2 on _____(date)

Dialysis: ☐ Yes ☐ No **Dialysis Start Date:** mm / dd / yyyy

Type of Dialysis: _____ **Dialysis Schedule:** _____

Current Dialysis Unit: _____ **Dialysis Access Mode:** _____

Patient has received blood transfusion: ☐ Yes ☐ No

If yes, number of times: _____ Date of most recent blood transfusion: _____

Potential Living Donor(s): ☐ Yes ☐ No **Previous Transplant:** ☐ Yes ☐ No

Combined Kidney Pancreas Assessment Request: ☐ Yes ☐ No

MEDICAL HISTORY/CONSULT ATTACHMENTS

REQUIRED:

- ☐ **Letter from referring nephrologist**
- ☐ **Current list of all patient medications**
- ☐ **Cancer screening as per Ontario guidelines**
- ☐ **Immunizations/Vaccination Record**
  - o Hepatitis B
  - o MMR

Attach if clinically significant:

- ☐ Social Work Assessment
- ☐ Other relevant consults, please specify:

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RECENT LABS AND DIAGNOSTIC TESTING RESULTS

All tests and assessments must be completed within one year of referral date unless specified otherwise.
Please attach the following results (if results are not available, please do not delay referral):

I. General Laboratory Testing

REQUIRED:

- ☐ **ABO blood group determination**
- ☐ **Electrolytes, Bicarbonate**
- ☐ **Urea, Creatinine**
- ☐ **Albumin, Total Protein**
- ☐ **Bilirubin**
- ☐ **CBC**
- ☐ **INR, PTT**
- ☐ **AST, ALT, ALKP**
- ☐ **Calcium, Phosphate**
- ☐ **Oral Glucose Tolerance Test**
- ☐ **HgbA1C**
- ☐ **Cholesterol/Triglyceride/HDL/LDL**
- ☐ **PTH**

Complete if clinically significant:

- ☐ Routine urinalysis
- ☐ Urine culture and sensitivity – *if still passing urine*
- ☐ Sickle Cell Screen - *For Black patients or patients with genetic origins in the Eastern Mediterranean or Indian subcontinent*

II. Cardiac Assessment

REQUIRED:

- ☐ **ECG (12-Lead)**
- ☐ **Echocardiogram**

Complete if clinically significant:

- ☐ Coronary Angiogram
- ☐ Cardiac perfusion testing (Exercise ECG/MIBI) - *For patients with heart failure, or angina, or diabetes, or BMI>34m or age >40 years with at least 3 of the following risks:increased cholesterol, smoker, hypertension, family history, BMI>30.*

III. Infectious Disease and Virology Testing

REQUIRED:

- ☐ **CMV IgG**
- ☐ **EBV IgG**
- ☐ **VZV antibody**
- ☐ **Tuberculosis skin test or equivalent**
- ☐ **Syphilis (VDRL)**
- ☐ **HIV serology**
- ☐ **HTLV1 and HTLV2**
- ☐ **Hepatitis C antibody**
- ☐ **Hepatitis B Core Antibody (HBcAb)**
- ☐ **Hepatitis B Surface Antigen (HBsAg)**
- ☐ **Hepatitis B Surface Antibody (HBsAb) -** *If patient is a non-responder, ensure that the patient has had 2 full series of vaccinations and is still non-reactive.*

Complete if clinically significant:

- ☐ HBV DNA - *if HBcAb or HBsAg positive*
- ☐ HepC RNA test - *if Hep C positive*

IV. Other Tests

REQUIRED

- ☐ **Chest x-ray (PA and lat)**
- ☐ **Abdominal/Renal ultrasound**

Complete if clinically significant:

- ☐ Renal biopsy, if available

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V. Additional Tests for PAEDIATRIC PATIENTS ONLY (<18 years)

REQUIRED

☐ **Immunization record** ☐ **Bone Age**

Complete if clinically significant: #

☐ Audiogram – *if <6 years* ☐ EEG – *if <6 years or history of seizures*

☐ Growth Curves (head circumference) - *if <6 years* ☐ ENT consult

Centre Specific Requirements

Transplant Centre	Additional Requirements
London Health Sciences Centre	☐ Doppler ultrasound of iliac and femoral vessels ☐ Urine for cytology ☐ Completed preoperative questionnaire Cancer Screening: ☐ Yearly PSA – *For men > 50 years old, or black men > 40 years old, or men > 40 with more than one family member diagnosed with prostate cancer* ☐ Colon cancer screening – *Colonoscopy or sigmoidoscopy for all patients > 50 years old (colonoscopy for all patients with personal or family history of colorectal cancer).*