ADULT LIVER TRANSPLANT REFERRAL FORM

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

For information on referring adult patients for liver transplantation please visit the Trillium Gift of Life Network website to access the referral criteria – [https://www.giftoflife.on.ca/en/professionals.htm#transref](https://www.giftoflife.on.ca/en/professionals.htm#transref).

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

London Health Sciences Centre
Liver Transplant Team
University Hospital
339 Windermere Road
London, Ontario N6A 5A5
Tel: (519) 685-8500 ext. 33354
Fax: (519) 663-3858

University Health Network
Liver Transplant Assessment Clinic
Toronto General Hospital
200 Elizabeth Street, NCSB11C-1222
Toronto, Ontario M5G 2N2
Tel: (416) 340-4800 ext. 6521
Fax: (416) 340-4779

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

TO BE COMPLETED BY TRANSPLANT PROGRAM/HEPATOLOGIST:

(Na)MELD: ___________ HCC: □ Yes □ No

URGENCY: □ High (within two weeks) □ Normal (next available appointment)

Referral Accepted for ALD Pilot Program: □ Yes □ No □ N/A

Date: ________________ Initials: ________________

TO BE COMPLETED BY TRANSPLANT PROGRAM UPON RECEIPT OF FORM:

Date Referral Form Received: ________________
**PATIENT DEMOGRAPHIC INFORMATION**

Patient Name:__________________________  Health Card #:________________

Version Code: ___

Date of Birth: _________________________  Sex: ☐ Male ☐ Female

Address/City:__________________________  Postal Code:___________

Phone:________________________

Patient Location: ☐ At Home  ☐ In Hospital  ☐ Other:________________________

Need for interpreter: ☐ Yes  ☐ No  If Yes, language __________________________

**PATIENT CLINICAL INFORMATION**

Patient ABO: ☐ A  ☐ B  ☐ AB  ☐ O  ☐ Unknown

Diagnosis: ☐ Cirrhosis  ☐ Liver Cancer  ☐ Other:________________________

Other Conditions: ☐ Diabetes  ☐ Heart Disease  ☐ Other:________________________

Diagnosis due to (select all that apply):

☐ HCV  ☐ HBV  ☐ NASH  ☐ AIH  ☐ PBC  ☐ PSC

☐ Alcohol; Period of Alcohol Abstinence:___________  ☐ Other:________________________

Complications:

☐ Ascites

☐ Controlled with diuretics  ☐ Requires regular paracentesis

☐ SBP, last episode:______________  ☐ Variceal Bleed, last episode:______________

☐ Encephalopathy, last episode:______________  ☐ Acute Kidney Injury (AKI)

☐ Other:________________________

Dialysis:

Is patient currently on Dialysis? ☐ Yes  ☐ No

Does patient require Dialysis during assessment at this centre? ☐ Yes  ☐ No
LAB RESULTS AND CONSULT ATTACHMENTS

Date of Lab Results: ____________________________

- Bilirubin total: _______ umol/l
- INR: _______
- Creatinine: _______ umol/l
- Sodium: _______ umol/l
- Platelet count: _______ x10^9/l

Please attach copies of the following reports, WHERE APPLICABLE:

Tests:
- Ultrasound, CT, MRI – Liver and Portal Vein
- Esophago-gastro-duodenoscopy (EGD)

Additional Tests (if available):
- Colonoscopy
- Pulmonary Function test
- Cardiac Test
- Consult Notes/Clinic Letters
- OR reports
- Other: ____________________________

ADDITIONAL COMMENTS

REFERRING PHYSICIAN

Referring Physician Name: ________________________________________

Referring Physician Organization: ____________________________________

Billing #: _____________________________ Phone #: _____________________________

Address/City: __________________________________ Postal Code: _______

Referral Form submitted to:  □ London Health Sciences Centre  □ University Health Network

Signature: _____________________________ Date Submitted: _____________________________
This section is to be completed for patients with Alcohol-associated Liver Disease (ALD) only.

To refer an ALD patient please complete both the medical and psychosocial information outlined below:

**ALCOHOL-ASSOCIATED LIVER DISEASE (ALD) – MEDICAL INFORMATION**

ALD Patient Type:  □ Severe Alcoholic Hepatitis (SAH)       □ Chronic ALD

**NOTE:** PATIENTS WITH SAH SHOULD BE REFERRED IMMEDIATELY TO A TRANSPLANT PROGRAM

**FOR SAH PATIENTS ONLY:**

First clinical presentation of alcoholic hepatitis:  □ Yes  □ No

Previous diagnosis of chronic liver disease:  □ Yes  □ No

Maddrey Score: __________  Date of Maddrey Score Test: ______________________

Lille Model Score: __________  Date of Lille Model Score Test: ______________________

SAH Biopsy Proven:  □ Yes  □ No  Date of Biopsy: ______________________^

(as applicable)

**ALCOHOL-ASSOCIATED LIVER DISEASE (ALD) – PSYCHOSOCIAL INFORMATION**

Has patient ceased alcohol use upon diagnosis of ALD?:

□ Yes  □ No

Date of liver disease diagnosis: ______________________

Date of last alcohol consumption: ______________________

Is patient willing to commit to long term abstinence from alcohol?:

□ Yes  □ No

Please provide details, if any:
Is patient willing to commit to alcohol use disorder treatment pre and post-transplant?:

☐ Yes  ☐ No

Please provide details, if any:

Patient has history of no more than one failed alcohol use disorder treatment:  ☐ Yes  ☐ No

If patient had one failed treatment, provide details below:

Name of Treating Addictions Specialist: ________________________________

Treating Addictions Specialist Contact Information (phone or email):

________________________________________

Treating Addictions Specialist Type:

☐ Psychologist  ☐ Psychiatrist  ☐ Other (please specify): ________________________________

Patient has absence of comorbid active substance use disorder, excluding cannabis use and tobacco use disorder:  ☐ Yes  ☐ No

Patient has stable housing/living situation:  ☐ Yes  ☐ No

Patient has identified Support Person/Caregiver:  ☐ Yes  ☐ No

If yes, provide details below:

Name of Identified Support Person: ________________________________

Relationship to Patient: ________________________________

Past Psychiatric History (complete as applicable):

Diagnoses:

________________________________________________________________________________
Treatments: ________________________________   Date of Admissions: ________________________

Name of Treating Mental Health Provider: _____________________________

History of self-injurious behaviour or suicide attempts: □ Yes  □ No
If yes, provide details:

History of non-adherence to medical or psychiatric treatment: □ Yes  □ No
If yes, provide details: