ADULT LIVER TRANSPLANT REFERRAL FORM

Referral Criteria for Adult Liver Transplantation:
- End-stage of chronic liver disease with hepatic decompensation (ascites, jaundice, hepatic encephalopathy or portal hypertensive GI bleed) and MELD ≥11 or Child-Pugh B ≥7 points
- Hepatocellular carcinoma
- Hepatopulmonary syndrome
- Fulminant hepatic failure
- Metabolic disorders of hepatic origin such as hereditary transthyretin amyloidosis, hyperoxaluria type I, and others

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

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 Rd.
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:

(No)MELD:_________  HCC: □ Yes □ No

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

Date:_____________  Initials:_____________
ADULT LIVER TRANSPLANT REFERRAL FORM

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: _______________
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
ADULT LIVER TRANSPLANT REFERRAL FORM

LAB RESULTS AND CONSULT ATTACHEMENTS

Date of Lab Results: ____________________________

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