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 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:**

(Na)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 ATTACHMENTS

Date of Lab Results: ____________________________

☐ Bilirubin total: _______ umol/l  ☐ INR: _______
☐ 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: ___________________