Trillium Gift of Life Network

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.

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**:_____

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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: _____

☐Encephalopahty, 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

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LAB RESULTS AND CONSULT ATTACHMENTS

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:** _____