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 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 Patient: ☐ Yes ☐ No ☐ N/A

Date: _____ **Initials:** _____

TO BE COMPLETED BY TRANSPLANT PROGRAM UPON RECEIPT OF FORM:

Date Referral Form Received: _____

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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

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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:** _____

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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 *(as applicable)* 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:

_____

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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:
