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 – 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 Office
Toronto General Hospital
585 University Avenue, 12PMB-100
Toronto, Ontario M5G 2L3
Tel: (416) 340-4800 ext. 8072
Fax: (416) 340-3875

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.

Due to the volume of referrals received, incomplete referrals may not be processed/accepted.

**PATIENT DEMOGRAPHIC INFORMATION**

**Patient Name:**_____ **Health Card #:**_____ **VC:**____

**Email Address:**_____

**Date of Birth:** _____ **Sex:** ◯ Male ◯ Female

**Address/City:**_____ **Postal Code:** _____

**Phone:**_____ ◯ Home ◯ Cell **Alt. Contact:** _____

**Patient Location:** ◯ At Home ◯ In Hospital ◯ Other: _____

**Need for interpreter:** ◯ Yes ◯ No **If Yes, language:** _____



Ontario Health

## Patient Clinical Information

**Patient ABO:** ◯ A ◯ B ◯ AB ◯ O ◯ Unknown

**Diagnosis:** ☐ Cirrhosis ☐ Liver Cancer ☐ Other: _____

**Diagnosis due to (select all that apply):**

☐ HCV ☐ HBV ☐ MASLD ☐ AIH ☐ PBC ☐ PSC

☐ Alcohol*; Period of Alcohol Abstinence: _____ ☐ Other: _____

*If alcohol, please complete pages 3-5

**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

Dialysis Schedule: ◯ MWF ◯ TTS ◯ Other (specify):_____

## Lab Results and Consult Attachments

**Date of Lab Results:** _____

☐ Bilirubin total: _____ umol/l ☐ Creatinine: _____ umol/l

☐ Sodium: _____ umol/l ☐ INR: _____

☐ MELD 3.0: _____ ☐ Albumin: _____g/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 ☐ Echocardiogram

☐ Consult Notes/Clinic Letters ☐ OR reports ☐ Relevant Biopsy Reports

☐ Other: _____ ☐ Cardiac Stress test

## 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:** _____

***Please ensure this section is completed for patients with Alcohol-associated Liver Disease (ALD). 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)* *(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:

Need this information in an accessible format? 1-877-280-8538, TTY 1-800-855-0511, info@ontariohealth.ca.
Document disponible en français en contactant info@ontariohealth.ca.