ADVANCED HEART FAILURE THERAPIES REFERRAL FORM

To refer a candidate for general assessment for advanced heart failure, heart transplantation, or Ventricular Assisted Devices (VADs), complete this form and attach all applicable documents. Please indicate if your patient needs an URGENT or STANDARD assessment.

Referral Criteria for Heart Transplantation

1) **Advanced Heart Failure:** Referral for heart transplantation should be considered for patients with advanced heart failure failing optimal medical and surgical (if appropriate) therapy. Such patients would have one or more of the following:
    - Late-stage heart failure due to any cause- AHA stage D
    - Patients who have significant cardiac dysfunction with marked symptoms of dyspnea, fatigue end-organ hypoperfusion at rest or with minimal exertion despite maximal medical therapy and/or surgical therapy
    - Refractory symptoms requiring specialized interventions to manage symptoms or prolong life
2) **Anticipated Survival:** Referral for heart transplantation should be considered for patients with poor anticipated survival without a transplant.
3) **Quality of Life:** Referral for heart transplantation should be considered for patients who would experience an unacceptable quality of life without a transplant.
4) **Arrhythmias:** Referral for heart transplantation should be considered for patients who have refractory life-threatening arrhythmias despite optimal medication, surgical, and device therapy.
5) **Heart Disease:** Referral for heart transplantation should be considered for patients with complex congenital heart disease with failed surgical palliation or who are not amenable to surgical palliation at acceptable risk.
6) **Angina:** Referral for heart transplantation should be considered for patients with refractory angina not amenable to further revascularization.

For information on referring adult patients for heart transplantation please visit the Trillium Gift of Life Network website to access the referral criteria – https://www.giftoflife.on.ca/en/professionals.htm#transref.

Considerations for Ventricular Assisted Devices (VADs)

Permanent VADs: Long-term VADs may be considered in both transplant-eligible and transplant-ineligible patients. These devices offer the capacity for improvement of end-organ function, enhanced quality of life, reduced heart failure hospitalizations, and a significant increase in survival. A comprehensive pre-assessment is needed as the criteria for VAD referral is multifactorial, involving multiple organ systems and exclusion criteria. Referral to an Advanced Heart Failure Cardiologist is recommended for patients who, despite optimal medical therapy, present with severe left ventricular dysfunction and functional impairment.

Submit the completed form, including all applicable documents to the appropriate transplant centre listed below:

Toronto General Hospital
Heart Function Clinic
Norman Urquhart Building, 5th Floor
585 University Ave.
Toronto, Ontario M5G 2N2
Fax: 416 340 4134

London Health Sciences Centre
Multi-Organ Transplant Program
339 Windermere Road
London, Ontario, N6A 5A5
Fax: 519 663 3858

University of Ottawa Heart Institute
Heart Transplant Program
40 Ruskin Street
Ottawa, Ontario K1Y 4W7
Fax: 613 696 7165

Trillium Gift of Life Network

ADVANCED HEART FAILURE THERAPIES REFERRAL FORM

Ontario

Referral For: ☐ **General Assessment** ☐ **Heart Transplantation** ☐ **Ventricular Assisted Device**

Referral Type: ☐**URGENT** ☐**STANDARD**

Referring MD: _____ **Contact #:** _____

Referring Centre: _____ **Postal Code:** _____

Referral Form submitted to: _____ **Date Submitted:** _____ **Date Received:** _____

PATIENT DEMOGRAPHIC INFORMATION

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

Date of Birth: _____ **Sex:** ☐ Male ☐ Female ☐ Unknown

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

Phone Number: _____ **Language Spoken:** _____

PATIENT CARDIAC INFORMATION

Patient ABO (attach report): _____ **Height:** _____ **Weight:** _____

Diagnosis: _____ **New Referral?** ☐ Yes ☐ No (re-transplant)

Baseline Characteristics:

EF ____ % NYHA Class: ☐1 ☐2 ☐3 ☐4

BP: _____ QRS > 120 ms: ☐Yes ☐No

Devices: ☐Yes ☐No

Devices (AICD, Pacer, etc):_____

Laboratory Data:

Hb: _____ Uric Acid: _____ Na: _____

% Lymphocytes: _____ Total Cholesterol: _____ Creatinine: _____

NT-proBNP (optional): _____

Medications:

Lasix _____mg (☐od ☐bid ☐tid) Metalozone _____mg (☐od ☐bid)

HCTZ _____mg od Beta-blocker: ☐Yes ☐No

ACEI: ☐Yes ☐No Allopurinol: ☐Yes ☐No

ARB: ☐Yes ☐No Mineralocorticoid Receptor Antagonist: ☐Yes ☐No

Statin: ☐Yes ☐No Entresto: ☐Yes ☐No

Anticoagulation Medications: ☐Yes ☐No Ivabradine: ☐Yes ☐No

LAB RESULTS **Please attach the copies of the following reports, WHERE APPLICABLE:**

☐2D echocardiogram ☐Abdominal Ultrasound ☐Angiogram and CD

☐Bone Density Scan ☐CT Scan of Chest ☐Hemodynamic Monitoring

☐Blood Test Results ☐Heart Stress Tests ☐ECG

☐Chest x-ray ☐Urine Tests ☐Doppler (carotid/femoral)

☐PFT / RHC / CPET

PAST MEDICAL HISTORY

History of recurrent hospitalization for Heart Failure:

☐No ☐Yes, please explain: _____

History of cancer:

☐No ☐Yes, please explain: _____

History of peripheral vascular disease (i.e., carotid, AAA, PVD):

☐No ☐Yes, please explain: _____

History of psychosocial conditions (i.e., social support, current substance abuse):

☐No ☐Yes, please explain: _____

History of neurological conditions (i.e., stroke and associated deficits):

☐No ☐Yes, please explain: _____

History of gastrointestinal bleeding:

☐No ☐Yes, please explain: _____

Diabetes:

☐No ☐Yes, please explain: _____

COPD or lung related problems:

☐No ☐Yes, please explain: _____

Past surgeries:

☐No ☐Yes, please explain: _____

Please include any past medical history that may be relevant to patient assessment:

REFERRING CARDIOLOGIST

Patient Referral Type: ☐ Outpatient ☐ Inpatient

☐ **Referral letter attached**

Name: _____ **Phone #:** _____

Signature: _____ **Date:** _____

To be completed by Transplant Cardiologist:

Urgency: ☐ High ☐ Average

Name: _____ **Signature**: _____ **Date Received:** _____