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
ADVANCED HEART FAILURE THERAPIES
REFERRAL FORM

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:

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REFERRING CARDIOLOGIST

Patient Referral Type: ☐ Outpatient ☐ Inpatient
☐ Referral letter attached

Name: ____________________________ Phone #: __________________
Signature: ______________________ Date: ______________________

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To be completed by Transplant Cardiologist:

Urgency: ☐ High ☐ Average

Name: ____________________________ Signature: __________________ Date Received: ____________