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.

**To refer a candidate for heart transplantation, complete this form and attach all applicable documents.**

Please indicate if your patient needs an URGENT or STANDARD assessment.

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: 613 761 4327

The completion of this form will expedite your patient’s investigations and subsequent consideration for transplantation. Thank you for your cooperation in providing this material.
**ADULT HEART TRANSPLANTATION REFERRAL FORM**

Referral Type: ☐ URGENT ☐ STANDARD  
Referring MD: ___________________________  Contact #: ___________________________  
Referring Centre: ___________________________  Postal Code: ___________  
Referral Form submitted to: ___________________________  Date Submitted: _______  Date Received: _______  

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**PATIENT DEMOGRAPHIC INFORMATION**

Patient Name: ___________________________  Health Card #: ___________________________  
Date of Birth: ___________________________  Sex: ☐ Male  ☐ Female  ☐ Unknown  
Address/City: ___________________________  Postal Code: ___________  
Language Spoken: ___________________________  

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**PATIENT CARDIAC INFORMATION**

Patient ABO (attach report): ___________________________  Height: _______  Weight: _______  
Diagnosis: ___________________________  New Referral? ☐ Yes  ☐ No (re-transplant)  
Baseline Characteristics:  
EF _____ % / grade _____  NYHA Class: ☐ 1 ☐ 2 ☐ 3 ☐ 4  
BP: _______  QRS > 120 ms: ☐ Yes  ☐ No  
Devices: ☐ Yes  ☐ No  
Biv Pacer: ☐ Yes  ☐ No  
AICD: ☐ Yes  ☐ No  
Laboratory Data:  
Hb: ___________  Uric Acid: ___________  Na: ___________  
% Lymphocytes: _______  Total Cholesterol: _______  Creatinine: ___________  
NT-proBNP (optional): ___________  
Medications:  
Lasix _____mg ( ☐ od ☐ bid ☐ tid)  
HCTZ _____mg od  
ACEI: ☐ Yes  ☐ No  
ARB: ☐ Yes  ☐ No  
Statin: ☐ Yes  ☐ No  
Allopurinol: ☐ Yes  ☐ No  
Aldosterone blocker: ☐ Yes  ☐ No  

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**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
ADULT HEART TRANSPLANTATION REFERRAL FORM

PAST MEDICAL HISTORY

History of cancer:
☐ No ☐ Yes, please explain:

History of peripheral vascular disease (i.e., carotid, AAA, PVD):
☐ No ☐ Yes, please explain:

Past surgeries:
☐ No ☐ Yes, please explain:

History of psychiatric 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:

COPD or lung related problems:
☐ 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: __________________________