

KIDNEY TRANSPLANT REFERRAL FORM

Referral Criteria for Kidney Transplantation: Patients should be referred for evaluation by the transplant program once renal replacement therapy is expected to be required within the next 12 months. Patients already requiring dialysis support should be referred for transplant evaluation as soon as their medical condition stabilizes. The criteria identified below are the agreed upon conditions for which a patient should be referred for a kidney transplant assessment:

- 1) Chronic Kidney Disease: Referral for kidney transplantation should be considered for patients with progressive Chronic Kidney Disease.
- 2) End Stage Renal Disease (ESRD): Referral for kidney transplantation should also be considered for patients with End Stage Renal Disease (ESRD).

To refer a candidate for kidney or kidney/pancreas transplantation complete this form and attach all applicable documents.

For patients seeking a living donor kidney transplant, please refer the patient to the transplant centre of your choice. For adult deceased donor kidney transplant, please refer the patient to the appropriate centre by consulting the table below:

Transplant Centre	LHIN Referral Catchment Area
London Health Sciences Centre	<ul style="list-style-type: none"> ▪ Erie St. Clair ▪ South West ▪ North East (Sudbury & Sault St. Marie) ▪ Waterloo Wellington ▪ North West
St. Joseph's Healthcare Hamilton	<ul style="list-style-type: none"> ▪ Hamilton Niagara Haldimand Brant ▪ Mississauga Halton
University Health Network or St. Michael's Hospital	<ul style="list-style-type: none"> ▪ Central West ▪ Toronto Central ▪ Central ▪ Central East ▪ North Simcoe Muskoka ▪ North East (North Bay)
Kingston General Hospital	<ul style="list-style-type: none"> ▪ South East
The Ottawa Hospital	<ul style="list-style-type: none"> ▪ Champlain

Submit the completed form to the appropriate transplant centre listed below:

University Health Network
Transplant Assessment Center c/o NCSB 12C-1217
Toronto General Hospital
585 University Ave.
Toronto, Ontario M5G 2N2
Fax (Kidney): 416-340-5209
Fax (Pancreas): 416-340-4340
Email: Kidneytransplantreferral@uhn.ca

St. Michael's Hospital
Kidney Transplant Program
61 Queen Street East, 9th Floor
Toronto, Ontario M5C 2T2
Fax: 416-867-3723
Email: kidneytransplantreferrals@smh.ca

St. Joseph's Healthcare Hamilton
Department of the Renal Transplant Program and Clinics
Level 0 Marian Wing
50 Charlton Ave E.
Hamilton, Ontario L8N 4A6
Fax: 905-521-6189

The Hospital for Sick Children
Renal Transplant Program
555 University Avenue, room 6428
Toronto, Ontario M5G 1X8
Fax: 416-813-5541

Kingston General Hospital
Renal Transplant Office, Burr Room 21.3.025
76 Stuart Street
Kingston, Ontario K7L 2V7
Fax: 613-548-1394

London Health Sciences Centre
Renal Recipient Transplant Office, UH Campus
339 Windermere Rd.
London, Ontario N6A 5A5
Fax: 519-663-3858

The Ottawa Hospital
Riverside Campus of The Ottawa Hospital,
Renal Transplant Office, Rm 518
1967 Riverside Dr.
Ottawa, Ontario K1H 7W9
Fax: 613-738-8489

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REFERRAL INFORMATION

Referring MD: _____ Date Received: _____
Referring Centre Contact Name: _____ Contact #: _____
Referring Centre: _____ Postal Code: _____
Referral Form submitted to: _____ Date submitted: _____

Medically Urgent Referral if yes, please indicate reason:

- Lack of vascular access Uremic complications in spite of maximal dialysis prescription
 Uremic cardiomyopathy Uremic Pericarditis Severe Uremic Neuropathy
 Other: _____

PATIENT INFORMATION

Patient Name: _____ Health Card #: _____
Date of Birth: mm / dd / yyyy Race: _____ Sex: Male Female
Address: _____ Postal Code: _____
Phone #: _____ Language Spoken: _____
GP Name: _____ GP Contact: _____

CLINICAL INFORMATION

ABO: ____ RH Factor: Positive Negative Height (m): ____ Weight (kg): ____ BMI: ____
Diagnosis: _____ eGFR: ____ ml/min/1.73m² on _____ (date)
Dialysis: Yes No Dialysis Start Date: mm / dd / yyyy
Type of Dialysis: _____ Dialysis Schedule: _____
Current Dialysis Unit: _____ Dialysis Access Mode: _____
Patient has received blood transfusion: Yes No
If yes, number of times: _____ Date of most recent blood transfusion: _____
Potential Living Donor(s): Yes No Previous Transplant: Yes No
Combined Kidney Pancreas Assessment Request: Yes No

MEDICAL HISTORY/CONSULT ATTACHMENTS

REQUIRED:

Letter from referring nephrologist Current list of all patient medications

Cancer screening as per [Cancer Care Ontario](#) guidelines

- Pap smear within 3 years for sexually active women
 Mammogram within 2 years for women ages 50 to 74
 Colon cancer screening with a fecal occult blood test or colonoscopy within 2 years for people ages 50 to 74

Attach if clinically significant:

Social Work Assessment Other relevant consults, please specify:

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RECENT LABS AND DIAGNOSTIC TESTING RESULTS

All tests and assessments must be completed within one year of referral date unless specified otherwise. Please attach the following results (if results are not available, please do not delay referral):

I. General Laboratory Testing

REQUIRED:

- | | |
|--|---|
| <input type="checkbox"/> ABO blood group determination | <input type="checkbox"/> AST, ALT, ALKP |
| <input type="checkbox"/> Electrolytes, Bicarbonate | <input type="checkbox"/> Calcium, Phosphate |
| <input type="checkbox"/> Urea, Creatinine | <input type="checkbox"/> Oral Glucose Tolerance Test |
| <input type="checkbox"/> Albumin, Total Protein | <input type="checkbox"/> HgbA1C |
| <input type="checkbox"/> Bilirubin | <input type="checkbox"/> Cholesterol/Triglyceride/HDL/LDL |
| <input type="checkbox"/> CBC | <input type="checkbox"/> PTH |
| <input type="checkbox"/> INR, PTT | |

Complete if clinically significant:

- | | |
|--|--|
| <input type="checkbox"/> Routine urinalysis | <input type="checkbox"/> Urine culture and sensitivity – <i>if still passing urine</i> |
| <input type="checkbox"/> Sickle Cell Screen - <i>For Black patients or patients with genetic origins in the Eastern Mediterranean or Indian subcontinent</i> | |

II. Cardiac Assessment

REQUIRED:

- | | |
|--|---|
| <input type="checkbox"/> ECG (12-Lead) | <input type="checkbox"/> Echocardiogram |
|--|---|

Complete if clinically significant:

- | |
|---|
| <input type="checkbox"/> Coronary Angiogram |
| <input type="checkbox"/> Cardiac perfusion testing (Exercise ECG/MIBI) - <i>For patients with heart failure, or angina, or diabetes, or BMI>34m or age >40 years with at least 3 of the following risks:increased cholesterol, smoker, hypertension, family history, BMI>30.</i> |

III. Infectious Disease and Virology Testing

REQUIRED:

- | | |
|---|--|
| <input type="checkbox"/> CMV IgG | <input type="checkbox"/> HTLV1 and HTLV2 |
| <input type="checkbox"/> EBV IgG | <input type="checkbox"/> Hepatitis C antibody |
| <input type="checkbox"/> VZV antibody | <input type="checkbox"/> Hepatitis B Core Antibody (HBcAb) |
| <input type="checkbox"/> Tuberculosis skin test or equivalent | <input type="checkbox"/> Hepatitis B Surface Antigen (HBsAg) |
| <input type="checkbox"/> Syphilis (VDRL) | <input type="checkbox"/> Hepatitis B Surface Antibody (HBsAb) |
| <input type="checkbox"/> HIV serology | <i>If patient is a non-responder, ensure that the patient has had 2 full series of vaccinations and is still non-reactive.</i> |
| <input type="checkbox"/> Measles, Mumps, & Rubella | |

Complete if clinically significant:

- | | |
|--|---|
| <input type="checkbox"/> HBV DNA - <i>if HBcAb or HBsAg positive</i> | <input type="checkbox"/> HepC RNA test - <i>if Hep C positive</i> |
|--|---|

IV. Other Tests

REQUIRED

- | | |
|---|---|
| <input type="checkbox"/> Chest x-ray (PA and lat) | <input type="checkbox"/> Abdominal/Renal ultrasound |
|---|---|

Complete if clinically significant:

- | |
|---|
| <input type="checkbox"/> Renal biopsy, if available |
|---|

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V. Additional Tests for PAEDIATRIC PATIENTS ONLY (<18 years)

REQUIRED

Immunization record

Bone Age

Complete if clinically significant:

Audiogram – *if <6 years*

EEG – *if <6 years or history of seizures*

Growth Curves (head circumference) - *if <6 years*

ENT consult

Centre Specific Requirements

Transplant Centre	Additional Requirements
London Health Sciences Centre	<p><input type="checkbox"/> Non-contrast AbdoPelvic CT to assess pelvic vessel calcifications for the following persons:</p> <ul style="list-style-type: none"> • All diabetics • Patients with peripheral vascular disease • Patients with previous transplants • PCKD <p><input type="checkbox"/> Urine for cytology</p> <p><input type="checkbox"/> Completed preoperative questionnaire</p> <p><u>Cancer Screening:</u></p> <p><input type="checkbox"/> Yearly PSA – <i>For men > 50 years old, or black men > 40 years old, or men > 40 with more than one family member diagnosed with prostate cancer</i></p>
St. Michael's Hospital	<p><u>Cancer Screening:</u></p> <p><input type="checkbox"/> Yearly PSA – <i>For men > 50 years old, or black men > 40 years old, or men > 40 with more than one family member diagnosed with prostate cancer</i></p>