Trillium Gift of Life Network

KIDNEY TRANSPLANT REFERRAL FORM

Referral Guidelines for Kidney Transplantation:

Kidney transplant should be considered for patients with Chronic Kidney Disease (CKD) or End Stage Renal Disease (ESRD). Referring Regional Renal Programs (RRPs) must have robust processes to annually assess patients' eligibility for kidney transplant referral. The guidelines identified below are the agreed upon conditions for which a patient should be referred for a kidney transplant assessment.

Do not proceed with referral if any of the following apply:	• Active malignancy (metastatic cancer) • Critical inoperable valve disease • Active irreversible ischemic progressive heart disease • Severe (LVEF < 20%) left ventricle dysfunction (unless possibly uremic in origin) • Patient has not consented to transplant

Timing of Referral

In general, pre-emptive kidney transplantation is the preferred form of renal replacement therapy and should be encouraged where feasible. As per the ORN's provider resource and the MCKC Best Practices document, patients should be referred for kidney transplant if:	
Patient with potential living donors:	• eGFR less than 15 mL/min per 1.73 m^2 or • ≥ 25% chance of requiring renal replacement therapy within 2 years, as assessed with a valid equation, see www.kidneyfailurerisk.com or • Expect dialysis will be needed in the next 2 years.
Patients without potential living donors:	• Patient is receiving dialysis • Patient is expected to receive dialysis within the next year.

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

Transplant Program	
Kingston General Hospital Fax: 613-548-1394	The Ottawa Hospital Fax: 613-738-8489
London Health Sciences Centre Fax: 519-663-3858 Email: kidneytransplantreferral@lhsc.on.ca	Unity Health Toronto – St. Michael's Fax: 416-867-7418 Email: kidneytransplantreferrals@smh.ca
St. Joseph's Healthcare Hamilton Fax: 905-521-6189	University Health Network Fax (Kidney): 416-340-5209 Fax (Pancreas): 416-340-4340 Email: Kidneytransplantreferral@uhn.ca

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REFERRAL INFORMATION

Referring MD____ **Contact #:** ______________________

Primary Contact: _____________________________________ **Postal Code:** ___________________

Referring Centre: _______________________________________ **Date submitted:** _________________

Referral Form submitted to: ____

☐ **Medically Urgent Referral** if yes, please indicate reason:

☐Lack of dialysis access ☐Uremic cardiomyopathy ☐Uremic Neuropathy ☐Other:_____________

Combined Kidney Pancreas Assessment Request: ☐Yes ☐No

PATIENT INFORMATION

Patient Name: ______________________________ **Health Card #:** __________________________

Date of Birth: mm / dd / yyyy **Race:** _____________ **Sex:** ☐ Male ☐ Female

Interpreter Required?: ☐ Yes ☐ No **If yes, what language?** ______________________

Address: ____ **Postal Code:** _________

Phone #: ___________________________________ **Patient Email:** ________________________

GP Name: ________________________________ **GP Contact:** _____________________________

CLINICAL INFORMATION

ABO: ____ **RH Factor:** ☐Positive ☐Negative **Height (m):** ___ **Weight (kg):** ____ **BMI:** ____

Kidney Disease Diagnosis: ____

____

eGFR: ______ **ml/min/1.73m2 on** mm / dd / yyyy **OR** **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: _________________________

Does patient have Potential Living Donor(s): ☐Yes ☐ No **Previous Transplant:** ☐Yes ☐ No

Potential Donor's Relationship to Patient: ______________________ **Previous Living Donor:** ☐Yes ☐ No

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REQUIRED MEDICAL HISTORY, LABORATORY AND DIAGNOSTIC TESTS

All test results must be **less than one year old**, unless otherwise specified. Please check off each box to indicate that you have included the test results.

Medical History

☐Letter from referring nephrologist
☐Current list of all patient medications

Cancer screening as per Cancer Care Ontario guidelines:

☐Pap test every 3 years for anyone with a cervix who has ever been sexually active
☐Mammogram every 2 years
☐Colon cancer screening with fecal immunochemical tests (FIT) every 2 years

General Laboratory Testing

☐ABO blood group determination
☐AST, ALT, ALKP
☐Electrolytes, Bicarbonate
☐Calcium, Phosphate
☐Urea, Creatinine
☐Oral Glucose Tolerance Test
☐Albumin, Total Protein
☐HgbA1C
☐Bilirubin
☐Cholesterol/Triglyceride/HDL/LDL
☐CBC
☐PTH
☐INR, PTT

Cardiac Assessment

☐ECG (12-Lead)
☐Echocardiogram

Infectious Disease and Virology Testing

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

Other Tests

☐Chest x-ray (PA and lat)
☐Complete Abdominal/Renal ultrasound

ADDITIONAL TESTS

The following tests are required within 60 days of referral date and will be needed prior to determining suitability for transplant listing. Please send as soon as possible.
All test results must be less than one year old, unless otherwise specified. Please check off each box to indicate that you have included the test results.

Attach if available and/or clinically significant:

☐Social Work Assessment
☐Renal biopsy
☐Routine urinalysis
☐Urine culture and sensitivity – *if still passing urine*
☐Sickle Cell Screen - *For Black patients or patients with genetic origins in the Eastern Mediterranean or Indian subcontinent*
☐Coronary Angiogram
☐Cardiac perfusion testing (Exercise ECG/MIBI) - *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.*
☐HBV DNA - *if HBcAb or HBsAg positive*
☐HepC RNA test - *if Hep C positive*

☐Other relevant consults, please specify:

Additional Tests for Paediatric Patients Only (<18 years):

☐Immunization record
☐Bone Age

Additional Tests for Pancreas Patients Only:

☐C-peptide
☐Cardiac perfusion testing

Attach if available and/or clinically significant:

☐Audiogram – *if <6 years*
☐EEG – *if <6 years or history of seizures*
☐Growth Curves (head circumference) - *if <6 years*
☐ENT consult

☐Other relevant consults, please specify: