

Liver Transplant Referral Form (Outpatient)

Referral Date: (DD/MM/YYYY): _____

Referral must be submitted by specialists. Incomplete referrals will **NOT** be accepted.

PATIENT CONTACT INFORMATION			
Last Name:		First Name:	
Address			
BirthDate (DD/MM/YYYY): _____		<input type="checkbox"/> Male <input type="checkbox"/> Female	
City:		Province:	
Postal Code:			
BC PHN:		Other PHN:	
Home Phone:			
Height _____ cm		Weight _____ kg	
Cell Phone:			
<input type="checkbox"/> English Speaker		<input type="checkbox"/> Other Language _____	
<input type="checkbox"/> Translator Needed			
CAREGIVER/SUPPORT PERSON		Name:	
Relationship to Patient:		Home Phone:	
		Cell Phone:	
REFERRING SPECIALIST		FAMILY PHYSICIAN	
MSP #:		MSP #:	
Last Name		Last Name	
First Name		First Name	

Indication for Liver Transplant Assessment (12 years of age and older)

- Cirrhosis Liver Cancer Other _____

in the context of

- HCV HBV Alcohol & Abstinence Demonstration
 NASH PSC PBC AIH Other _____

complicated by

- Ascites controlled by diuretics require regular paracentesis
 SBP last episode (MM/YYYY) _____
 Variceal bleed last episode (MM/YYYY) _____
 Encephalopathy last episode (MM/YYYY) _____
 Other _____

Cardiac Risk Factors

- Hyper-tension Diabetes Hyper-lipidemia Personal History CAD Family History CAD

	Smoking	Excessive Alcohol	Non-therapeutic Drugs
Current user?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Previous user?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Last use: (DD/MM/YYYY)	_____	_____	_____
Attended rehab or counselling in the last 2 years?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

TO BE SUBMITTED WITH REFERRAL FORM

MANDATORY REPORTS

- Relevant consult notes
 Blood work including CBC, INR/PTT, Lytes, urea, creatinine, LFTs, albumin within last 2 months
 Abdominal imaging within last 6 months
 Medication list including drug allergies

CONDITION-SPECIFIC REPORTS

- HCV: Hepatitis C genotype report
 HCC: Dynamic phase imaging either contrast enhanced MRI or 4 phase abdominal CT scan within last 3 months
 HIV positive: HIV viral load and CD4 count
 FAP: Neurology consult notes

If available, please provide the following

- Echocardiogram report
 Endoscopy report(s)
 Liver biopsy report
 All abdominal imaging for previous 2 years

Office Use Only			
<input type="checkbox"/> Referral Package Complete		<input type="checkbox"/> Referral Criteria Met	
Date _____		<input type="checkbox"/> Yes <input type="radio"/> Emergent <input type="radio"/> Urgent Na MELD _____ Child-Pugh _____ <input type="checkbox"/> No; advised referring specialist	
Reviewed by	Doctor	RN	SW
Review date	____/____/____	____/____/____	____/____/____
Appt Date (DD/MM/YYYY) ____/____/____		<input type="checkbox"/> Arranged for Translation Services	

Indications

At least one of the following:

1. Decompensated liver disease with a minimum Na MELD score greater than 12 (based on labwork within 2 months) and/or a minimum Child-Pugh score of 9
2. Severe hepatic encephalopathy
3. Refractory ascites
4. Spontaneous bacterial peritonitis
5. Refractory variceal hemorrhage
6. Severe pruritis, refractory to medical management
7. Worsening renal function (hepatorenal syndrome) under nephrologist's care
8. Hepatocellular carcinoma (HCC)
 - Within Milan / San Francisco criteria
 - No further local regional options
9. Hepatopulmonary syndrome with positive bubble echocardiogram
10. Metabolic disorder that would be cured by liver transplant
11. Familial Amyloidosis Polyneuropathy (FAP) with neurological symptoms

Exclusion Criteria

1. Non-compliance with medical management
2. Use of illicit drugs and/or excessive use of therapeutic drugs within the last six months
3. Ongoing smoker (cigarettes, e-cigarettes, marijuana) and unwilling to quit
4. Absence of 24/7 social support for recovery period after transplant
5. Unable or not committed to adhere to medical treatment
6. Refusal of **all** blood products and blood components transfusions
7. Unmanaged psychiatric disorder
 - Recent suicide attempt
 - Ongoing dementia
8. Any disease or illness with a predicted 5 year survival rate less than 50%
9. Pulmonary arterial systolic hypertension greater than 50mm Hg and pulmonary vascular resistance greater than 240 dynes in right heart catheterization
10. Right heart failure
11. Advanced cardiac disease
12. HIV viral load detectable on HAART therapy and/or CD4 count less than 200
13. Persistent extrahepatic infection despite medical management
14. BMI greater than 40 or less than 15; with serious co-morbidity risk(s)
15. Advanced debilitation with poor functional status and limited mobility
16. Chronic kidney disease on dialysis unless undergoing concurrent kidney transplant assessment
17. Na MELD greater than 40

For urgent inpatient liver transplant referrals, please discuss with
VGH Liver Transplant Gastroenterologist on call
via VGH Switchboard 604.875.4111