Vancouver CoastalHealth

Solid Organ Transplant Clinic
Gordon & Leslie Diamond Health Center
5th Floor, 2775 Laurel Street, Vancouver BC V5Z1M9

Fax: 604.875.5236
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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): _____ ❒ *Male* ❒ *Female*		*City:*	*Province:* *Postal Code:*
BC PHN:	*Other PHN:*	*Home Phone:*	*Cell Phone:*
Height: _____*cm*	*Weight:* _____*kg*	***Email:***	
❒ *English Speaker:*	❒ *Other Language:* _____	❒ *Translator Needed:*	
CAREGIVER/SUPPORT PERSON	*Name:*	*Home Phone:*	
Relationship to Patient:		*Cell Phone:*	
REFERRING SPECIALIST MSP #:		**FAMILY PHYSICIAN** MSP #:	
Last Name:	*First Name:*	*Last Name:*	*First Name:*
Phone:	*Fax:*	*Phone:*	*Fax:*

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?	❒ Yes ❒ No	❒ Yes ❒ No	❒ Yes ❒ No
Previous user?	❒ Yes ❒ No	❒ Yes ❒ No	❒ Yes ❒ No
Date of Last use: (DD/MM/YYYY)	_____	_____	_____
Attended rehab or counselling in the last 2 years?		❒ Yes ❒ No	❒ Yes ❒ No

❒ **If YES, please provide us with supporting documents**

TO BE SUBMITTED WITH REFERRAL FORM

MANDATORY REPORTS

- ❒ Relevant consult notes that include Medication list and Allergies
- ❒ Bloodwork within last 2 months including CBC, INR/PTT, Lytes, Urea, Creatinine, LFT's, Albumin. For HCC including tumor markers AFP, CEA, Ca 19-9
- ❒ FIT (over 50 yrs old)
- ❒ Abdominal Imaging within 2-3 months including Contrast CT Abdo/MRI OR Abdo U/S if contraindicated due to low GFR
- ❒ CXR
- ❒ ECG
- ❒ ECHO (TTE)
- ❒ MIBI (for Diabetic and/or over 60 years old)
- ❒ CT chest non contrast (long time ex-smoker or recently quit smoking)
- ❒ Gastroscopy in the last year if history of portal hypertension

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

- ❒ Colonoscopy report(s)
- ❒ Liver biopsy report
- ❒ All abdominal imaging for previous 2 years

Office Use Only			
❒ Referral Package Complete Date _____		❒ Referral Criteria Met ❒ Yes ❍Emergent ❍Urgent Na MELD_____Child-Pugh_____ ❒ No; advised referring specialist	
Reviewed by	Doctor	RN	SW
Review date	____/____/_____	____/____/_____	____/____/_____
Appt Date (DD/MM/YYYY) ____/____/_____		❒ 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 Amyloidoisis 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