Trillium Gift of Life Network

KIDNEY TRANSPLANT REFERRAL FORM

Referral Criteria for Kidney Transplantation: [illegible]

1. [illegible]
2. [illegible]

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

[illegible]

Transplant Centre	LHIN Referral Catchment Area
[illegible]	[illegible]
St. Joseph's Healthcare Hamilton	[illegible]
[illegible] *or* St. Michael's Hospital	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]

[illegible]

University Health Network
[illegible]

St. Michael's Hospital
[illegible]

St. Joseph's Healthcare Hamilton
[illegible]

The Hospital for Sick Children
[illegible]

Kingston General Hospital
[illegible]

London Health Sciences Centre
[illegible]

The Ottawa Hospital
[illegible]

Ontario Health
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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**

☐ [illegible] ☐ [illegible] ☐ [illegible]
☐ [illegible] ☐ [illegible] ☐ [illegible]
☐ Other [illegible]

PATIENT INFORMATION

Patient Name: _____ **Health Card #:** _____

Date of Birth: mm / dd / yyyy **Race:** _____ **Sex:** [illegible] ☐ Male [illegible] ☐ Female [illegible]

Address: [illegible] _____ **Postal Code:** _____

Phone #: _____ **Language Spoken:** _____

GP Name: _____ **GP Contact:** _____

CLINICAL INFORMATION

ABO: [illegible] **RH Factor:** ☐ [illegible] ☐ [illegible] **Height (m):** ___ **Weight (kg):** ____ **BMI:** ____

Diagnosis: [illegible] **eGFR:** _____ [illegible]

Dialysis: ☐ [illegible] ☐ [illegible] **Dialysis Start Date:** mm / dd / yyyy

Type of Dialysis: _____ **Dialysis Schedule:** _____

Current Dialysis Unit: _____ **Dialysis Access Mode:** _____

Patient has received blood transfusion [illegible] ☐ [illegible] ☐ [illegible]

[illegible]

Potential Living Donor(s): ☐ [illegible] ☐ [illegible] **Previous Transplant:** ☐ [illegible] ☐ [illegible]

Combined Kidney Pancreas Assessment Request: ☐ [illegible] ☐ [illegible]

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*

[illegible]

☐ [illegible] or [illegible] ☐ Other [illegible]

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RECENT LABS AND DIAGNOSTIC TESTING RESULTS

[illegible]

I. General Laboratory Testing

REQUIRED:

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

Co[illegible]

- ☐ [illegible]
- ☐ [illegible] *if still passing urine*
- ☐ [illegible] *For Black patients or patients with genetic origins in the Eastern Mediterranean or Indian subcontinent*

II. Cardiac Assessment

REQUIRED:

- ☐ **ECG (12-Lead)**
- ☐ **Echocardiogram**

Co[illegible]

- ☐ [illegible]
- ☐ [illegible] *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.*

III. Infectious Disease and Virology Testing

REQUIRED:

- ☐ **CMV IgG**
- ☐ **EBV IgG**
- ☐ **VZV antibody**
- ☐ **Tuberculosis skin test or equivalent**
- ☐ **Syphilis (VDRL)**
- ☐ **HIV serology**
- ☐ **Measles, Mumps, & Rubella**
- ☐ **HTLV1 and HTLV2**
- ☐ **Hepatitis C antibody**
- ☐ **Hepatitis B Core Antibody (HBcAb)**
- ☐ **Hepatitis B Surface Antigen (HBsAg)**
- ☐ **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.

Co[illegible]

- ☐ [illegible] *if HBcAb or HBsAg positive*
- ☐ [illegible] *if Hep C positive*

IV. Other Tests

REQUIRED

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

Co[illegible]

- ☐ [illegible]

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

REQUIRED

- ☐ **Immunization record**
- ☐ **Bone Age**

Co ete c c t

- ☐ d o r – *if <6 years*
- ☐ – *if <6 years or history of seizures*
- ☐ ro t C r e e d c r c ere ce *if <6 years*
- ☐ T co t

Centre Specific Requirements

Transplant Centre	Additional Requirements
London Health Sciences Centre	☐ o co tr t bdo e c CT to e e e c e e c c c t o or t e o o er o • d bet c • te t t er er c r d e e • te t t re o tr t • C D ☐ r e or c to o ☐ Co eted reo er t e e t o re C cer cree ☐ e r – *For men > 50 years old, or black men > 40 years old, or men > 40 with more than one family member diagnosed with prostate cancer*
St. Michael's Hospital	C cer cree ☐ e r – *For men > 50 years old, or black men > 40 years old, or men > 40 with more than one family member diagnosed with prostate cancer*