UHN Toronto General Hospital

The Liver Transplant Assessment Clinic

Toronto Liver Transplant Program

Referral Form

Fax to (416) 340-4779

Leslie Lilly, MD, FRCP(C)
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1. Patient Name .... **Last** .... **First** .... **Middle**

DOB ____________________ (D D M M Y Y Y Y) **OHIP No** ____________________

Home Address ***Number/Street*** ....

City ....

Postal Code ______________

Phone ____________________ ☐ *home* ☐ *cell* ☐ *work*

Interpreter Needed: Y ☐ N ☐ Language Required:

To be completed by Transplant Hepatologist

Na-MELD

CTP ☐ A ☐ B ☐ C; pts

HCC ☐ > TTV+AFP

☐ Urgency high

☐ Urgency average

☐ Schedule for ________ (M M)

Date ....

Initials ....

2. Indication for Liver Transplant Assessment ☐ **Cirrhosis** ☐ **Liver Cancer** ☐ Other ....

in the context of ☐ HCV ☐ HBV ☐ Alcohol *(Date of Abstinence: __________)* ☐ NASH

☐ PSC ☐ PBC ☐ AIH ☐ Other ....

complicated by ☐ Ascites ☐ controlled with diuretics ☐ requiring regular paracentesis

☐ SBP last episode ⊥⊥⊥ ⊥⊥⊥⊥⊥ (M M Y Y Y Y)

☐ Variceal bleed last episode ⊥⊥⊥ ⊥⊥⊥⊥⊥ (M M Y Y Y Y)

☐ Encephalopathy last episode ⊥⊥⊥ ⊥⊥⊥⊥⊥ (M M Y Y Y Y)

☐ Other ....

Lab Results ____________________ (D D M M Y Y Y Y) Bilirubin total ________umol/l INR ________ Creatinin ______ umol/l

Serum Na ________mmol/l

Liver Imaging ☐ ***copy of report must be attached*** **Gastroscopy** ☐ ***copy of report must be attached***

3. Comments ....

....

4. Referring Physician

Name .... ***Billing No.*** ____________________

Number/Street .... ***City.*** ....

Postal Code ________________ ***Phone*** ____________________

Date ____________________ (D D M M Y Y Y Y) ***Signature***..................................

Toronto General Hospital – Pre-Liver Assessment Clinic
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