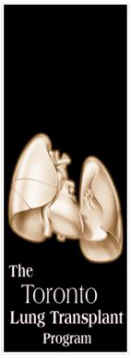
UHN Toronto General Toronto Western Princess Margaret Toronto Rehab



Toronto Adult Lung and Heart-Lung Transplantation
Referral Form

This Referral form has been designed to streamline the referral process and transplant assessment.

KEY POINTS

** The following are contraindications for lung transplant **referral**: active smoking, BMI ≥38.
If your patient does not have the above contraindications please complete this form.

1. Please complete all sections - any questions which are not applicable or available should be marked **N/A**.
2. When specific results are not available but have been requested please mark as **pending**.
3. **Copies of Imaging (CT, coronary angiography, etc) should be sent on CD with this form**.
4. Copies of complete reports of investigations can be appended to this form.
5. Serial PFT and 6-minute walk reports are very helpful and should be included when available.

Any questions please feel free to contact the transplant coordinator at **416-340-4800, ext 5714**

PLEASE FAX THE COMPLETED FORM AND DOCUMENTS TO: 416-340-4044

Please mail CDs of imaging studies to: Lung Transplant Assessment Office, 12 PMB-100, 585 University Ave, Toronto, ON M5G 2N2

Thank you for your co-operation.

URGENCY of Referral

☐High urgency: please explain_____
☐Transplant currently indicated, standard urgency
☐Transplant not yet indicated – early referral

PERSONAL DETAILS

PATIENT NAME:

Age: _____ DOB: _____ Health Card number: _____

Patient Phone Number: _____

Patient Address: _____

Family Contact Name: _____ Phone: _____

Need for interpreter: No / Yes Language: _____

Need for isolation: No / Yes Explain:_____

REFERRING RESPIROLOGIST: _____

Telephone Number: _____FAX: _____

E-mail address (optional):_____

Family MD Name: _____

Family MD Telephone Number: _____ Fax number: _____

Patient Height: _____ circle in / m Weight:_____ circle lbs / kg Date of weight:-

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RESPIRATORY HISTORY

Primary Diagnosis: _____

Secondary Diagnoses Respiratory: _____

Smoker (Tobacco): NO YES

Pack Year History: _____ Stopped when: _____

Sputum Microbiology in past 2 years (mandatory for CF/bronchiectasis patients, & if applicable for others; please attach relevant C&S results)

- ☐ Pseudomonas aeruginosa
- ☐ MRSA
- ☐ MSSA
- ☐ Burkholderia cenocepacia
- ☐ Other Burkholderia
- ☐ Aspergillus
- ☐ Mycobacterium Abscessus
- ☐ Other NTM
- ☐ Other _____

Comments: _____

Oxygen at home: NO YES

Rate at rest: _____ Rate with activity: _____

Hemoptysis: NO YES Details: _____

Pneumothorax: NO YES Details (note if pleurodesis): _____

Thoracic Surgery: NO YES Details: _____

Has the patient ever required ventilation? NO YES

If yes (circle all that apply) noninvasive ventilation / intubation

Details: _____

_____

_____

Clinical disease course: include details on prior treatments for lung disease, approximate start and stop dates, response, rate of decline, life threatening exacerbations etc.

Details: _____

_____

_____

_____

_____

_____

_____

_____

_____

Any adverse reactions to corticosteroids or other immunosuppressive drugs?

_____

_____

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Pulmonary Function Tests: Please attach PFT's for last 2 years (if relevant)

Last Arterial Blood Gas if available

pH _____ pO2 _____ pCO2 _____ HCO3 _____ Sats _____ FIO2_____ Date_____

Current Exercise Capacity

* Please attach all 6MW reports for last 2 years

Exercise tolerance (describe or MRC class) _____

6 minute walk test? NO YES If yes most recent distance _____meters

Lowest saturation _____ Performed on air / oxygen at _____ liters /min

Wheelchair/scooter NO YES

Pulmonary Rehab NO YES Dates/ details: _____

PAST MEDICAL HISTORY

Current or previous:

Sinus Disease	NO	YES	Details: _____
Hypertension	NO	YES	Details: _____
Hyperlipidemia	NO	YES	Details: _____
Stroke	NO	YES	Details: _____
Thromboembolism	NO	YES	Details: _____
Heart Disease	NO	YES	Details: _____
Peripheral Vasc Disease	NO	YES	Details: _____
Renal Disease	NO	YES	Details: _____
Liver Disease	NO	YES	Details: _____
Diabetes	NO	YES	Details: _____
Osteoporosis	NO	YES	Details: _____
Malignancy	NO	YES	Details: _____
GERD reflux/dysmotility	NO	YES	Details: _____
Tube feeding	NO	YES	Details: _____
Pregnancies	NO	YES	N/A
Chronic pain	NO	YES	Details: _____

Prescriber of opioids:_____

Other **Non-respiratory** Diagnoses:

1 _____

2_____

3_____

4 _____

Current Medication/s

Please list all medications the patient is taking (name, dose, frequency, route)

_____

_____

_____

_____

_____

_____

ALLERGIES: NO YES Details: _____

Adherence issues: NO YES Details: _____

Family and Social History

Marital status: (Please Circle) Single / Married or Common Law / Separated or Divorced / Widowed

Family support available: _____

Lives alone: NO YES

Alcohol Intake:

Current: NO YES Details: _____

Prior: NO YES Details: _____

Recreational Drug Use (past/present): NO YES Details: _____

Relevant Family Medical History:

_____

Psychological assessment

Current or Previous History of:

Depression: NO YES Details: _____

Panic attacks: NO YES Details: _____

Anxiety: NO YES Details: _____

Other Psychiatric conditions: NO YES Details: _____

CLINICAL INVESTIGATIONS

Please send the report for: Echo, CXR, CT thorax & Stress test if performed. Please send chest imaging studies on CD.

Echocardiogram (Date performed):

Result _____

Chest x-ray (Last performed):

Result _____

CT Thorax (Last date performed):

Result _____

Nuclear cardiac stress test (>40yrs) (Date performed):

Result _____

ANY OTHER COMMENTS:

_____

_____

_____

_____

NAME: _____ Signed _____

DATE: _____