The Liver Transplant Assessment Clinic

Referral Form

Fax to (416) 340-4779

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1. Patient Name (Last, First, Middle)

DOB **OHIP No**

Home Address ***Number/Street***

City ***Postal Code***

Phone ☐ *home* ☐ *cell* ☐ *work*

Alt. Phone **Email**

Interpreter Needed: Y ☐ N ☐ Language Required:

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2. Indication for Liver Transplant Assessment ☐ **Cirrhosis** ☐ **Liver Cancer** (☐ *HCC Bridging Clinic)*

in the context of: **Primary** Chose from Menu

Secondary Chose from Menu

Alcohol Date of Abstinence: (☐ *ALD Protocol)*

Other

Complicated by ☐ Ascites Choose from Menu

☐ SBP: last episode
☐ Variceal bleed: last episode
☐ Encephalopathy**:** last episode
☐ Other

Lab Results

Bilirubin $_{total}$ **umol/l** **INR**

Serum Na **mmol/l** **Creatinine** **umol/l**

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

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3. Comments

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4. Referring Physician

Name **Billing No.**

Number/Street **City**

Postal Code **Phone**

Date **Signature**

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