

**ADULT LIVER TRANSPLANT REFERRAL FORM**

**To refer a candidate for adult liver transplantation, please complete this form and attach all applicable documentation.**

**Appointments will only be made following triage of a completed referral form by a Consultant Hepatologist. To assist in this process please fill in this form carefully with as much supportive information as possible.**

**Please note that incomplete forms will not be triaged and will be returned to the referral source.**

**Please email completed forms to** [**liver.secretary@svuh.ie**](mailto:liver.secretary@svuh.ie)

***For office use only***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Hepatologist** | **Date Received** | **Date**  **Triaged** | **Timeframe for LTC OPA** | **LTC OPA**  **date** |
| **Dr Zita Galvin** |  |  |  |  |
| **Dr Audrey Dillon** |  |  |  |  |
| **Dr Masood Iqbal** |  |  |  |  |
| **Dr Omar El Sherif** |  |  |  |  |

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| **Referral for Elective Liver Transplant** | | | | |
| Name: | | Known as: | | |
| Address: | | | | |
| Contact number: | | DOB: | | |
| NOK: | Relationship: | | | Contact No: |
| Nationality: | Interpreter Required:  No□ Yes □ | | | Language: |
| **Psycho-social Support Concerns**  *The National Liver Transplant Programme requires all patients under consideration for transplant to have a named person who commits to supporting them through the process. Please advise if any known concerns or give any additional relevant information below:* | | | | |
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| **Alcohol History**  *All patients* ***regardless of aetiology*** *referred for liver transplant assessment should be told to stop drinking alcohol; this includes all 0% alcohol drinks.* | | | | |
| Abstinent: No □ Yes □ | | Date of last alcohol: | | |
| Documented advised to stop Alcohol:  No □ Yes □ | | Date advised to stop alcohol: | | |
| Peth result & date: | | Number of Peth Tests: | | |
| Date first admitted with Alcohol related illness: | | Details of any relapses: | | |
| Counselling Recommended:  No □ Yes □  Counselling started:  No □ Yes □ | | Counsellor’s name & contact details: | | |
| **Recreational Drug History**  *Please give information regarding drug use and treatment below* | | | | |
| No History □ | Current user □ | | | Ex drug user □ |
| Comment: | | | | |
| **Smoking History**  *All patients referred for liver transplant assessment should be told to stop smoking.* | | | | |
| No History □ | Current user □ | | | Ex-smoker □ |
| Referred to Smoking cessation: No □ Yes □ | | | | |
| Comment: | | | | |
| **Aetiology of Chronic Liver Disease**  *Please tick all relevant sections* | | | | |
| □ Alcohol-related Liver Disease (ArLD) | | □ Metabolic dysfunction-associated steatotic liver disease (MASLD) | | |
| □ Met-ALD (Patients with MASLD who consume excess alcohol *(>140g and 210 g/week for females and males respectively)* | | □ Autoimmune Hepatitis (AIH) | | |
| □ Primary Biliary Cholangitis (PBC) | | □ Primary Sclerosing Cholangitis (PSC) | | |
| □ Hepatitis C Virus (HCV)  SVR No □ Yes □  Treatment Details - | | □ Hepatitis B Virus (HBV)  Viral Suppression - No □ Yes □  Treatment Details- | | |
| □ Cryptogenic Cirrhosis | | □ Cystic Fibrosis Related Liver Disease | | |
| □ Polycystic Liver Disease | | □ Chronic Budd Chiari | | |
| □ Other: | | | | |
| **Indications for Liver Transplant**  *Please complete all relevant sections AND include all blood results with referral* | | | | |
| **MELD-Na SCORE AT REFERRAL: \_\_\_\_\_\_\_\_\_\_\_\_\_**  **INR: Na: Creatinine: Bilirubin:** | | | | |
| □ Jaundice | | □ Coagulopathy | | |
| □ HE | No of episodes: | No of Hospital admissions: | | Current Treatment: |
| □ Ascites | Diuretic Treatment: No □ Yes □  *Give Details:* | | | |
| Diuretic Resistant: No □ Yes □  Date stopped: | | | |
| LVP-  No □ Yes □ | Frequency: | | Volume removed: |
| SAAG Level: | | | Total Protein Level: |
| SBP: No □ Yes □  *Give details of antibiotic prophylaxis:* | | | |
| Hydrothorax: No□ Yes □  *Give details of Pleural Fluid analysis if tested:* | | | |
| Cytology: No□ Yes □  *Give details:* | | | |
| □ Oesophageal Varices | Present No □ Yes □  Previous Bleed: No □ Yes □ | | | |
| Endoscopic Therapy: No □ Yes □  Date of last OGD: | | | |
| Beta- Blockade: No □ Yes □  *Give details:* | | | |
| TIPSS: No □ Yes □  *Give details:* | | | |
| Medications Trialled: | | | |
| □ Pruritus | Current Treatment: | | | |
| Medications Trialled: | | | |
| Plasmapheresis: No □ Yes □  *Give Details:* | | | |
| □ Cholangitis | No of episodes in last year: | | | Date last episode: |
| Culture proven: No □ Yes □  *Give details:* | | | |
| Antibiotic Therapy: No □ Yes □  *Give details:* | | | |
| Current prophylaxis: No □ Yes □  *Give details:* | | | |
| Ca19-9 Result: | | | |
| Brushings *(if available*): No □ Yes □  Date & Report: | | | |
| Details of other investigations including ERCP/MRCP/EUS: | | | |
| □ Hepatopulmonary Syndrome | Lying PO2 level:  Date of test: | | Standing PO2 level:  Date of Test: | |
| Requires O2 Therapy: No □ Yes □  *Give details:* | | | |
| Bubble Echo: No □ Yes □  Date & Report: | | | |
| □ Hepato-renal Syndrome | AKI : No □ Yes □ *Give details:* | | | |
| CKD : No □ Yes □ *Give details:* | | | |
| Peak Creatinine & trend of Renal function: | | | |
| Renal USS Report (if done): | | | |
| Urine Dipstick (Na & protein result) | | | |
| □ HCC | Chronic Liver Disease:  No □ Yes □ | | Specify: | |
| Date of Diagnosis: | | | |
| Imaging proven: No □ Yes □  Reports & imaging sent to SVUH: No □ Yes □  HCC Rad MDT : No □ Yes □  Next Imaging date due: | | | |
|  | Biopsy proven No □ Yes □  Report included: | | | |
| No of lesions at diagnosis: | | Size of lesions at diagnosis: | |
| Initial AFP & Date: | | Latest AFP & Date: | |
| Treatments to date: | | | |
| Current size& number of lesions: | | | |
| Latest imaging: | | Next due: | |
| □ CCA | PSC No □ Yes □ | | | |
| Hilar CCA No □ Yes □  Size: | | | |
| Intrahepatic CCA No □ Yes □  Size: | | | |
| Ca19-9 Result: | | | |
| Brushings *(if available*): No □ Yes □  Date & Report: | | | |
| Details of other investigations including ERCP/MRCP/EUS: | | | |
| □ Nutritional Decline /sarcopenia: | Weight- Height- BMI-  Dietitian review : No □ Yes □ Date: | | | |
| □ Other | *Give full details* | | | |
| **Co- Morbidities - Please provide any relevant consult letters** | | | | |
| □ Diabetes: No □ Yes □  Diet controlled □ Oral hypoglycaemic’ s □ Insulin □ | | | | |
| □ Cardiovascular: No □ Yes □  Atrial Fibrillation □ Ischaemic Heart Disease □ Other: Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| □ Cancers: No □ Yes □  *Details of previous cancers and treatments including dates and letter from Oncologist re prognosis* | | | | |
| *Please include details of past medical and surgical history* | | | | |
| **Medications**  *Please list all current medications* | | | | |
| 1. | | 6. | | |
| 2. | | 7. | | |
| 3. | | 8. | | |
| 4. | | 9. | | |
| 5. | | 10. | | |
| **Investigations-**  *Additional Reports/opinions including Cardiology, Respiratory, Oncology, Endocrinology and Nephrology IF available should also be included.* | | | | |
| **Mandatory** | | **If available** | | | |
| 1. Serial bloods including FBC, Coag & INR, U+E’S & LFT’s, viral screen, AFP and PETH | | 1. Endoscopy Report | | |
| 2. Imaging | | *2. Echo* | | |
| *3.* | | *3. PFTs* | | |
| *4.* | | *4. Any relevant consults* | | |
| **Referring Consultant & Contact details for further information & updates, Please include contact email address** | | | | |
|  | | | | |
| **Date of last review by referring team (please include any recent clinic letters):** | | | | |
| **Date & signature:** | | | | |
| **Additional Information** | | | | |
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