

 **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**

***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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