London Health Sciences Centre
Multi-Organ Transplant Program

**Fax: (519) 663-3858**
Email: livertransplantreferral@lhsc.on.ca

**Liver Transplant Program-Hepatology**
*M Qasim Khan MBBS, FRCPC*
*Karim Qumosani MD, FRCPC*
*Anouar Teriaky MD, FRCPC, MPH*
*David Hudson MD, FRCPC*

# Liver Transplant Assessment Referral Form

***Urgent referrals should be called directly to the Liver Transplant Hepatologist on call at University Hospital (519-685-8500).***

## Patient Information:

**Name:** ______________ ______________ ______________
*Last* *First* *Middle*

**Date of Birth:** ______________ ______ **Health Card #:** ______________ **MRN:** ______________
*YYYY / MMM / DD* *Age* *Number* *VC* *Number*

**Home Address:** ______________ ______________ ______________
*Number / Street* *City* *Postal Code*

**Phone Numbers:** ______________ ______________ ______________
*Home* *Cell* *Work*

**Email** (if available): ______________

**Height:** ______________ cm **Weight:** ______________ kg **BMI** ______________

**Interpreter Required?** ☐Yes / ☐No Language: ______________

**Family Doctor:** ______________ **Family MD Phone**: ______________

## Diagnosis:

☐HCV ☐HBV
☐ MASH ☐ Alcohol Date of Last Drink: ______________ ALD? ☐
☐PSC ☐PBC ☐Autoimmune Hepatitis
☐Cholangiocarcinoma ☐ Hepatocellular Carcinoma

Other: ______________

## Decompensating Features:

☐Ascites: ☐controlled with diuretics ☐requires regular paracentesis

☐ SBP: last episode ______________
*YYYY MMM*

☐ Variceal Bleed: last episode ______________
*YYYY MMM*

☐ Encephalopathy: last episode ______________
*YYYY MMM*

## Lab Results:

Date: ______________

Bilirubin total: ______________ umol/l

Creatinine: ______________ umol/l

Serum Na: ______________ umol/l

INR: ______________ NaMELD: ______

## Reports & Notes

Please attach a copy of the following (if done):

☐US Abdomen/Pelvis
☐Triphasic CT Abdomen/Pelvis
☐Colonoscopy/ EGD
☐PFTs

## Referring Physician:

Name: ______________

Postal Code: ______________

Date Submitted: ______________
*YYYY / MMM / DD*

Internal Use Only:

COVID VACC________ ☐ Patient Called

*For further information about the LHSC Liver Transplant Program and listing criteria, please refer to our website: www.lhsc.on.ca/multi-organ-transplant-program/liver-transplant*