



Opinion Referral Form

Patient Information		
Name:	Health Card #:	LHSC MRN:
Street Address:	City:	Postal Code:
Blood Type:	Diagnosis:	
Dialysis Start Date:	Type:	Centre:
Check all that apply and describe:		
<input type="checkbox"/> Malignancy (please include treatment, plan of care and pathology):		
<input type="checkbox"/> Neurological disease:		
<input type="checkbox"/> Cardiac disease:		
<input type="checkbox"/> PVD disease:		
<input type="checkbox"/> GI/liver disease:		
<input type="checkbox"/> Haematological disease:		
<input type="checkbox"/> Psychosocial/adherence/substance misuse concerns:		
<input type="checkbox"/> Obesity/BMI:		
<input type="checkbox"/> Surgical issues:		
<input type="checkbox"/> Infections:		
Other:		
Specific Question for Transplant Program:		
Referral Submitted by		
Nephrologist:	Phone:	
Coordinator/Nurse:	Phone:	
Date Submitted:		