KIDNEY TRANSPLANT REFERRAL FORM

Pre-emptive kidney transplantation is the preferred form of renal replacement therapy and should be encouraged where feasible. Any patient who has progressive Chronic Kidney Disease (CKD) or End Stage Renal Disease (ESRD) should be considered. Potential transplant recipients should be referred for evaluation by the transplant program once renal replacement therapy is expected to be required within the next 12 months. Patients already requiring dialysis support should be referred for transplant evaluation as soon as their medical condition stabilizes.

To refer a candidate for kidney or kidney/pancreas transplantation complete this form and attach all applicable documents.

Submit the completed form to the appropriate transplant centre listed below:

University Health Network
Transplant Assessment Center c/o NCSB 12C-1217
Toronto General Hospital
585 University Ave.
Toronto, Ontario M5G 2N2
Fax: 416-340-5209

St. Michael's Hospital
Kidney Transplant Program
61 Queen Street East, 9th Floor
Toronto, Ontario M5C 2T2
Fax: 416-867-3678

The Hospital for Sick Children
Renal Transplant Program
555 University Avenue, room 6428
Toronto, Ontario M5G 1X8
Fax: 416-813-5541

Kingston General Hospital
Renal Transplant Office, Burr Room 21.2.025
76 Stuart Street
Kingston, Ontario K7L 2V7
Fax:613-548-1394

St. Joseph's Healthcare Hamilton
Department of the Renal Transplant Program and Clinics
Level 0 Marian Wing
50 Charlton Ave E.
Hamilton, Ontario L8N 4A6
Fax: 905-521-6189

London Health Sciences Centre
Renal Recipient Transplant Office, UH Campus
339 Windermere Rd.
London, Ontario N6A 5A5
Fax: 519-663-3858

The Ottawa Hospital
Riverside Campus of The Ottawa Hospital,
Renal Transplant Office, Rm 518
1967 Riverside Dr.
Ottawa, Ontario K1H 7W9
Fax: 613-738-8489

For patients seeking a living donor kidney transplant, please refer the patient to the transplant centre of your choice. For deceased donor kidney transplant, please refer the patient to the appropriate centre by consulting the table below:

Transplant Centre	LHIN Referral Catchment Area
London Health Sciences Centre	▪ Erie St. Clair ▪ South West ▪ Waterloo Wellington ▪ North West ▪ North East (Sudbury & Sault St. Marie)
St. Joseph's Healthcare Hamilton	▪ Hamilton Niagara Haldimand Brant ▪ Mississauga Halton
University Health Network *or* St. Michael's Hospital	▪ Central West ▪ Toronto Central ▪ Central ▪ Central East ▪ North Simcoe Muskoka ▪ North East (North Bay)
Kingston General Hospital	▪ South East
The Ottawa Hospital	▪ Champlain

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Referring MD: ______________________________ **Contact:** ____________________

Referral/Dialysis Centre Contact Name: ______________________________ **Contact:** ____________________

Referral Form submitted to: ______________________________ **Date submitted:** ________________

Date Received: ________________

Patient Demographic Information

Patient Name: ______________________ **Health Card #:** ______________________

Date of Birth: ______________________ **Sex:** ☐ Male ☐ Female ☐ Unknown

Address/City: ______________________ **Postal Code:** ______________________

Language Spoken: ______________________ **Race:** ______________________

Patient Clinical Information

Patient ABO (attach report): ________________ **Height:** _______ **Weight:** _______ **BMI:** ________

Diagnosis: ______________________ **eGFR:** ________ ml/min/1.73m^2 on ____________(date)

Dialysis: ☐ Yes ☐ No **Type of Dialysis:** ______________________

Dialysis Schedule: ______________________ **Dialysis Start Date:** ______________________

Current Dialysis Unit: ______________________ **Potential Living Donor(s):** ☐ Yes ☐ No

Combined Kidney Pancreas Assessment? ☐ Yes ☐ No

New Referral? ☐ Yes ☐ No (re-transplant)

Medical History/Consult Attachments

Please attach the following information, <u>WHERE APPLICABLE:</u>

☐ Letter from referring nephrologist

☐ Current list of all patient medications

☐ Hepatitis B vaccination record

☐ Social Work Assessment - *The assessment should include psychosocial risks, plan for medical coverage, transplant transportation, and post transplant accommodation.*

Other relevant consults, please specify:

Gift of Life
Don de vie

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RECENT LABS AND DIAGNOSTIC TESTING RESULTS

All tests and assessments must be completed within one year of referral date unless specified otherwise.
WHERE APPLICABLE, attach the following results (if results are not available, please do not delay referral):

I. Assessments

- ☐ ABO with RH Factor
- ☐ Electrolytes
- ☐ Urea Creatinine
- ☐ Albumin, Total Protein
- ☐ Bilirubin
- ☐ CBC/Platelet Count
- ☐ INR, PTT
- ☐ Calcium
- ☐ Phosphate
- ☐ ALP
- ☐ AST
- ☐ ALT
- ☐ Routine urinalysis
- ☐ Urine culture and sensitivity *–For patients still passing urine*
- ☐ Cholesterol/Triglyceride/HDL/LDL
- ☐ PTH
- ☐ Oral Glucose Tolerance Test
- ☐ HgbA1C
- ☐ Sickle Cell – *For Black patients or patients with genetic origins in the Eastern Mediterranean or Indian subcontinent*

II. Cardiac Assessment

- ☐ Chest x-ray (PA and lat)
- ☐ ECG Tracing
- ☐ Echocardiogram
- ☐ MIBI or Bruce Protocol Stress Test – *For patients with Heart failure, or angina, or Diabetes, or BMI >34, or age >40 years with at least 3 of the following risks; increased cholesterol, smoker, hypertension, family history, BMI >30, or if echocardiogram is abnormal.*

III. Malignancy Screen

- ☐ Mammogram within 2 years – For women >50
- ☐ Yearly PSA – *For men > 50 years old, or black men > 40 years old, or men > 40 with more than one family member diagnosed with prostate cancer*
- ☐ Pap smear within 3 years – For sexually active women
- ☐ Colon cancer screening *–For all patients > 50 years old (colonoscopy for all patients with personal or family history of colorectal cancer).*

IV. Infectious disease and virology testing

- ☐ HIV Combo screen
- ☐ HTLV1 and HTLV2
- ☐ CMV IgG
- ☐ EBV (VCA, EBNA, EA-D)
- ☐ Tuberculosis (TB) skin test
- ☐ Syphilis (VDRL)
- ☐ Varicella Zoster titre
- ☐ Measles
- ☐ Mumps
- ☐ Rubella
- ☐ Hepatitis C antibody (anti-HCV-Ab)
- ☐ Hepatitis B Surface Antigen (HBsAG)
- ☐ Hepatitis B Surface Antibody (HBsAb) *– if patient is a non-responder, ensure that patient has had at least 2 full series of vaccinations and is still non-reactive*

V. Other Tests

- ☐ Renal biopsy, if done
- ☐ Abdominal/Renal ultrasound

VI. Tests for PAEDIATRIC PATIENTS ONLY (<18 years)

- ☐ Immunization record
- ☐ Growth Curves (including Head Circumference) - *if <6 years*
- ☐ Bone Age
- ☐ EEG – *if <6 years or history of seizures*
- ☐ Audiogram – *if <6 years*
- ☐ ENT consult – *if abnormal audiogram or history of recurrent Otitis Media or severe snoring*