

## KIDNEY TRANSPLANT REFERRAL FORM

**Referral Criteria for Kidney Transplantation:** Patients 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. The criteria identified below are the agreed upon conditions for which a patient should be referred for a kidney transplant assessment:

- 1) Chronic Kidney Disease: Referral for kidney transplantation should be considered for patients with progressive Chronic Kidney Disease.
- 2) End Stage Renal Disease (ESRD): Referral for kidney transplantation should also be considered for patients with End Stage Renal Disease (ESRD).

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

For patients seeking a living donor kidney transplant, please refer the patient to the transplant centre of your choice. For adult 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	<ul style="list-style-type: none"> <li>▪ Erie St. Clair</li> <li>▪ South West</li> <li>▪ North East (Sudbury &amp; Sault St. Marie)</li> <li>▪ Waterloo Wellington</li> <li>▪ North West</li> </ul>
St. Joseph's Healthcare Hamilton	<ul style="list-style-type: none"> <li>▪ Hamilton Niagara Haldimand Brant</li> <li>▪ Mississauga Halton</li> </ul>
University Health Network <i>or</i> St. Michael's Hospital	<ul style="list-style-type: none"> <li>▪ Central West</li> <li>▪ Toronto Central</li> <li>▪ Central</li> <li>▪ Central East</li> <li>▪ North Simcoe Muskoka</li> <li>▪ North East (North Bay)</li> </ul>
Kingston General Hospital	<ul style="list-style-type: none"> <li>▪ South East</li> </ul>
The Ottawa Hospital	<ul style="list-style-type: none"> <li>▪ Champlain</li> </ul>

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 (Kidney): 416-340-5209  
Fax (Pancreas): 416-340-4340  
Email: Kidneytransplantreferral@uhn.ca

**St. Michael's Hospital**

Kidney Transplant Program  
61 Queen Street East, 9<sup>th</sup> Floor  
Toronto, Ontario M5C 2T2  
Fax: 416-867-3678

**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

**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

**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

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## REFERRAL INFORMATION

Referring MD: \_\_\_\_\_ Date Received: \_\_\_\_\_  
Referring Centre Contact Name: \_\_\_\_\_ Contact #: \_\_\_\_\_  
Referring Centre: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Referral Form submitted to: \_\_\_\_\_ Date submitted: \_\_\_\_\_

- Medically Urgent Referral** if yes, please indicate reason:
- Lack of vascular access       Uremic complications in spite of maximal dialysis prescription  
 Uremic cardiomyopathy       Uremic Pericarditis       Severe Uremic Neuropathy  
 Other: \_\_\_\_\_

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## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Health Card #: \_\_\_\_\_  
Date of Birth: mm / dd / yyyy Race: \_\_\_\_\_ Sex:  Male  Female  
Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Language Spoken: \_\_\_\_\_  
GP Name: \_\_\_\_\_ GP Contact: \_\_\_\_\_

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## CLINICAL INFORMATION

ABO: \_\_\_\_ RH Factor:  Positive  Negative      Height (m): \_\_\_\_ Weight (kg): \_\_\_\_ BMI: \_\_\_\_  
Diagnosis: \_\_\_\_\_ eGFR: \_\_\_\_\_ ml/min/1.73m<sup>2</sup> on \_\_\_\_\_ (date)  
Dialysis:  Yes  No      Dialysis Start Date: mm / dd / yyyy  
Type of Dialysis: \_\_\_\_\_ Dialysis Schedule: \_\_\_\_\_  
Current Dialysis Unit: \_\_\_\_\_ Dialysis Access Mode: \_\_\_\_\_  
Patient has received blood transfusion:  Yes  No  
If yes, number of times: \_\_\_\_\_ Date of most recent blood transfusion: \_\_\_\_\_  
Potential Living Donor(s):  Yes  No      Previous Transplant:  Yes  No  
Combined Kidney Pancreas Assessment Request:  Yes  No

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## MEDICAL HISTORY/CONSULT ATTACHMENTS

### REQUIRED:

- |   |  |
|---|--|
| <input type="checkbox"/> Letter from referring nephrologist         | <input type="checkbox"/> Current list of all patient medications |
| <input type="checkbox"/> Cancer screening as per Ontario guidelines | <input type="checkbox"/> Immunizations/Vaccination Record        |
|   | <input type="radio"/> Hepatitis B                                |
|   | <input type="radio"/> MMR  |

Attach if clinically significant:

- Social Work Assessment       Other relevant consults, please specify:

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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. Please attach the following results (if results are not available, please do not delay referral):

### I. General Laboratory Testing

**REQUIRED:**

- |  |   |
|--|---|
| <input type="checkbox"/> ABO blood group determination | <input type="checkbox"/> AST, ALT, ALKP                   |
| <input type="checkbox"/> Electrolytes, Bicarbonate     | <input type="checkbox"/> Calcium, Phosphate               |
| <input type="checkbox"/> Urea, Creatinine              | <input type="checkbox"/> Oral Glucose Tolerance Test      |
| <input type="checkbox"/> Albumin, Total Protein        | <input type="checkbox"/> HgbA1C                           |
| <input type="checkbox"/> Bilirubin                     | <input type="checkbox"/> Cholesterol/Triglyceride/HDL/LDL |
| <input type="checkbox"/> CBC                           | <input type="checkbox"/> PTH                              |
| <input type="checkbox"/> INR, PTT                      |   |

Complete if clinically significant:

- |  |  |
|--|--|
| <input type="checkbox"/> Routine urinalysis  | <input type="checkbox"/> Urine culture and sensitivity – <i>if still passing urine</i> |
| <input type="checkbox"/> Sickle Cell Screen - <i>For Black patients or patients with genetic origins in the Eastern Mediterranean or Indian subcontinent</i> |  |

### II. Cardiac Assessment

**REQUIRED:**

- |  |   |
|--|---|
| <input type="checkbox"/> ECG (12-Lead) | <input type="checkbox"/> Echocardiogram |
|--|---|

Complete if clinically significant:

- |   |
|---|
| <input type="checkbox"/> Coronary Angiogram   |
| <input type="checkbox"/> Cardiac perfusion testing (Exercise ECG/MIBI) - <i>For patients with heart failure, or angina, or diabetes, or BMI&gt;34m or age &gt;40 years with at least 3 of the following risks:increased cholesterol, smoker, hypertension, family history, BMI&gt;30.</i> |

### III. Infectious Disease and Virology Testing

**REQUIRED:**

- |   |  |
|---|--|
| <input type="checkbox"/> CMV IgG                              | <input type="checkbox"/> HTLV1 and HTLV2   |
| <input type="checkbox"/> EBV IgG                              | <input type="checkbox"/> Hepatitis C antibody  |
| <input type="checkbox"/> VZV antibody                         | <input type="checkbox"/> Hepatitis B Core Antibody (HBcAb)   |
| <input type="checkbox"/> Tuberculosis skin test or equivalent | <input type="checkbox"/> Hepatitis B Surface Antigen (HBsAg)   |
| <input type="checkbox"/> Syphilis (VDRL)                      | <input type="checkbox"/> Hepatitis B Surface Antibody (HBsAb) - <i>If patient is a non-responder, ensure that the patient has had 2 full series of vaccinations and is still non-reactive.</i> |
| <input type="checkbox"/> HIV serology                         |  |

Complete if clinically significant:

- |  |   |
|--|---|
| <input type="checkbox"/> HBV DNA - <i>if HBcAb or HBsAg positive</i> | <input type="checkbox"/> HepC RNA test - <i>if Hep C positive</i> |
|--|---|

### IV. Other Tests

**REQUIRED**

- |   |   |
|---|---|
| <input type="checkbox"/> Chest x-ray (PA and lat) | <input type="checkbox"/> Abdominal/Renal ultrasound |
|---|---|

Complete if clinically significant:

- |   |
|---|
| <input type="checkbox"/> Renal biopsy, if available |
|---|

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## V. Additional Tests for PAEDIATRIC PATIENTS ONLY (<18 years)

### REQUIRED

Immunization record

Bone Age

Complete if clinically significant:

Audiogram – *if <6 years*

EEG – *if <6 years or history of seizures*

Growth Curves (head circumference) - *if <6 years*

ENT consult

## Centre Specific Requirements

Transplant Centre	Additional Requirements
London Health Sciences Centre	<input type="checkbox"/> Doppler ultrasound of iliac and femoral vessels <input type="checkbox"/> Urine for cytology <input type="checkbox"/> Completed preoperative questionnaire  <u>Cancer Screening:</u> <input type="checkbox"/> Yearly PSA – <i>For men &gt; 50 years old, or black men &gt; 40 years old, or men &gt; 40 with more than one family member diagnosed with prostate cancer</i> <input type="checkbox"/> Colon cancer screening – <i>Colonoscopy or sigmoidoscopy for all patients &gt; 50 years old (colonoscopy for all patients with personal or family history of colorectal cancer).</i>