Trillium Gift of Life Network

KIDNEY TRANSPLANT REFERRAL FORM

Referral Guidelines for Kidney Transplantation

Kidney transplant should be considered for patients with Chronic Kidney Disease (CKD) or End Stage Kidney Disease (ESKD). Referring Regional Renal Programs (RRPs) must have robust processes to annually assess patients' eligibility for kidney transplant referral.

Do not proceed with referral if any of the following apply:	• Active malignancy (metastatic cancer) • Critical inoperable valve disease • Active irreversible ischemic progressive heart disease • Severe (LVEF < 20%) left ventricle dysfunction (unless possibly uremic in origin) • Patient has not consented to transplant assessment

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

Kidney Transplant Programs		Multi-Organ Transplant Programs	
KGH	Kingston General Hospital Fax: 613-548-2561 Email: KKTPFaxMailbox@kingstonhsc.ca	**LHSC**	London Health Sciences Centre Fax: 519-663-3858 Email: kidneytransplantreferral@lhsc.on.ca
SJHH	St. Joseph's Healthcare Hamilton Fax: 905-521-6189 Email: kidneytransplantreferral@stjoes.ca		
SMH	Unity Health Toronto – St. Michael's Hospital Email: kidneytransplantreferrals@smh.ca Fax: 416-867-7418	**UHN**	University Health Network Fax (Kidney): 416-340-5209 Fax (Pancreas): 416-340-4340 Email: Kidneytransplantreferral@uhn.ca
TOH	The Ottawa Hospital Fax: 613-738-8489		

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REFERRING PROGRAM INFORMATION

Referring Nephrologist: _____ **Contact #:** _____

Primary Nurse Contact: _____ **Postal Code:** _____

Referring Centre: _____ **Date submitted:** dd/mm/yyyy

Referring to Transplant Program At: ☐KGH ☐LHSC ☐SJHH ☐SMH ☐TOH ☐UHN

☐ **Medically Urgent Referral** *if yes, please indicate reason:*

☐Lack of dialysis access ☐Uremic cardiomyopathy ☐Uremic Neuropathy ☐Other:_____

Combined Kidney-Pancreas/Islet Assessment Request: ☐Yes ☐No

PATIENT INFORMATION

Patient Name: _____ **Health Card #:** _____

Date of Birth: dd/mm/yyyy **Race:** _____ **Sex:** ☐ Male ☐ Female

Gender is different than biological sex: ☐Yes ☐No

Interpreter Required?: ☐Yes ☐No **If yes, what language?** _____

Address: _____ **Postal Code:** _____

Phone #: _____ **Patient Email:** _____

Primary Care Physician Name & Contact #: _____

CLINICAL INFORMATION

ABO: _____ **Height (m):** _____ **Weight (kg):** _____ **BMI:** _____

Cause of Kidney Disease: _____

eGFR: _____ **ml/min/1.73m^2 on** dd/mm/yyyy **OR** **Dialysis Start Date:** dd/mm/yyyy
(start date mandatory if on dialysis)

Current Dialysis Unit: _____ **Dialysis Schedule:** _____

Type of Dialysis: _____ **Dialysis Access Type:**
☐AV fistula ☐AV graft ☐CVC ☐PD Catheter

Patient has received blood transfusion:
☐Yes ☐No ☐Unknown
If yes, number of times: _____ Date of most recent blood transfusion: dd/mm/yyyy

Previous Pregnancy: ☐Yes ☐ No **Previous Transplant:** ☐Yes ☐No

Does patient have Potential Living Donor(s): ☐Yes ☐No

Potential Donor's Relationship to Patient: _____

Is the patient a previous Living Donor: ☐Yes ☐No

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REQUIRED MEDICAL HISTORY, LABORATORY AND DIAGNOSTIC TESTS

All test results must be **less than one year old**, unless otherwise specified.
Incomplete referrals will not be accepted and/or may delay patient care. Tests with positive results should have appropriate follow-up coordinated. Please check off each box to indicate that you have included the test results.

Medical and Social History

- ☐ Overview of past medical history
- ☐ Current list of all patient medications
- ☐ Social work assessment

Up to date cancer screening as per Cancer Care Ontario guidelines for:

- ☐ Cervical cancer
- ☐ Breast cancer
- ☐ Colorectal cancer

General Laboratory Testing

- ☐ ABO blood group determination
- ☐ ALT, ALKP
- ☐ Electrolytes, Bicarbonate
- ☐ Calcium, Phosphate
- ☐ Urea, Creatinine
- ☐ Albumin, Total Protein
- ☐ HbA1C
- ☐ Bilirubin
- ☐ Cholesterol/Triglyceride/HDL/LDL
- ☐ CBC
- ☐ PTH
- ☐ INR, PTT

Cardiac Assessment

- ☐ ECG (12-Lead)
- ☐ Echocardiogram

Infectious Disease and Virology Testing

- ☐ CMV IgG
- ☐ EBV IgG
- ☐ HIV Ag/Ab
- ☐ Syphilis (VDRL)
- ☐ VZV antibody
- ☐ HTLV1 and HTLV2
- ☐ Measles, Mumps, & Rubella
- ☐ Hepatitis B Core Antibody (HBcAb)
- ☐ Hepatitis B Surface Antigen (HBsAg)
- ☐ Hepatitis B Surface Antibody (HBsAb) *If patient is a non-responder, ensure that the patient has had 2 full series of vaccinations and is still non-reactive.*
- ☐ Hepatitis C antibody
- ☐ 2-step Tuberculosis skin test or Interferon-Gamma Release Assay (IGRA) or equivalent

Other Tests

- ☐ Chest x-ray (PA and lat)
- ☐ Complete Abdominal/Renal ultrasound (with iliac doppler or non-contrast abdominal CT as per referring program)

ADDITIONAL TESTS

The following tests may be needed prior to determining suitability for transplant listing. Please attach these if they are available.

Attach if available and/or clinically significant:

- ☐ Renal biopsy
- ☐ Routine urinalysis
- ☐ Urine culture and sensitivity – *if still passing urine*
- ☐ Sickle Cell Screen - *For Black patients or patients with genetic origins in the Eastern Mediterranean or Indian subcontinent*
- ☐ Coronary Angiogram
- ☐ Cardiac PET CT
- ☐ Cardiac stress test (e.g. MIBI, dobutamine stress echo, exercise 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.*
- ☐ Hepatitis B DNA test - *if HBcAb or HBsAg positive*
- ☐ Hepatitis C RNA test - *if Hep C Ab positive*
- ☐ ENT consult

Additional Tests for Pediatric Patients Only (<18 years):

- ☐ Immunization record
- ☐ Bone Age
- ☐ Audiogram – *if <6 years*
- ☐ EEG – *if <6 years or history of seizures*
- ☐ Growth Curves (head circumference) - *if <6 years*

Additional Tests for Pancreas Patients Only:

- ☐ Refer to program specific requirements

Other relevant consults, please specify: