London Health Sciences Centre
Multi-Organ Transplant Program

Fax: (519) 663-3044
Email: livertransplantreferral@lhsc.on.ca
Phone: (519) 685-8500 x36670

Liver Transplant Program-Hepatology
M Qasim Khan MBBS, FRCPC
Karim Qumosani MD, FRCPC
Anouar Teriaky MD, FRCPC, MPH
David Hudson MD, FRCPC
Tamoor Afzaal 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: _____ (YYYY / MMM / DD) _____ (Age) **Health Card #:** _____ (Number) _____ (VC) **MRN:** _____ (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: _____ Alb: _____ MELD 3.0: _____

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