Lung Transplant Referral Letter

Please ensure the below are completed:

- Completed ALL Sections
- Full past medical history & medication list referral letter
- Recent pathology attached (within 4 weeks)
  - Cotinine available (Mandatory)
- Patient has copy of Chest Imaging (CD) for appointment
- Lung Function report (within last 2 years)

Your patient will not be booked or considered unless all sections are completed. The patient will receive a phone call for a booking if deemed appropriate for Transplant Assessment.

Yours sincerely,

Heart Lung Stream

St. Vincent's Hospital | Darlinghurst 2010 |

Heart Lung Clinical Stream
Development Date – Nov/2019 Reviewed June 2020. Adapted from and with Thanks to the Institution of Transplantation Freeman Hospital, Newcastle UK

Lung Transplant Assessment Referral Form

STRICTLY CONFIDENTIAL

Attention to:

Lung Transplant Physician

Dr: _____

c/o The Transplant Assessment Nurse
Heart & Lung Transplant Unit
St. Vincent's Hospital
390 Victoria Street Darlinghurst
Fax: 02 8382 3898
Email: svhs.heartlungclinic@svha.org.au

Lung Transplant Physicians

Dr Mark Benzimra	Dr Monique Malouf
Dr David Darley	Dr Rebecca Pearson
Prof Allan Glanville	Dr Adrian Havryk
A/Prof Marshall Plit	Dr Claire Thomson

Referral Date: / /

Date received by SVH (SVH Use only): / /

Patient available for appointment within 10 days?

☐ Yes (Short Notice List) ☐ No

Overview:

This form has been designed to streamline the referral process for potential lung transplant recipients. As a result, potential transplant candidates will be identified and formally assessed more efficiently.

Should you have any questions about this form or the referral process please contact the Transplant Co-ordinators at St Vincent's Hospital on 02 8382 3158.

- Please complete all sections, any questions which are not applicable should be marked as N/A.
- When specific results are not available but have been requested please mark as "pending".
- Please attached completed investigation reports to the Transplant Assessment Form.

Referring Specialist:
Name:
Phone:
Fax:
Email:
Address:
Provider number:

General Practitioner details
Name:
Phone:
Fax:
Email:
Address:
Provider number:

Patient / client details:

Name:	Address:
Date of Birth: / /	
Preferred name/s:	Mobile:
Sex: ☐ Male ☐ Female ☐ Indeterminate	Phone: Work:
Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss	Email:
Medicare No: #	☐ DVA ☐ Work Cover Other ☐
Elective status: ☐ Public ☐ Private	Aboriginal/Torres Strait Islander: ☐ Yes ☐No
Preferred language:	Interpreter required? ☐ Yes ☐No

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Current In-patient: ☐ Yes ☐ No **Hospital admitted at:** … Age:

Overview referral

Clinical disease course: include details on prior treatments for lung disease, approximate start and stop dates, response, rate of decline, life-threatening exacerbations etc.

Previous Ventilation: ☐ NIV ☐ Mechanical Ventilation

Urgency: ☐ High Urgency ☐ Transplant Currently Indicated ☐ Early Referral (Not yet indicated)

Respiratory History

Primary Diagnosis date: …

Non-Respiratory 1. …

2. …

3. …

Smoking status

Ex-smoker ☐ Yes ☐ No

Pack Year History date: …

Cotinine Level _____ Date completed: _____

(Mandatory – within last 4 weeks)

Never smoked ☐ Yes ☐ No

Lung Function (Please attach lung function from the past 2 years)

FEV1 =	**L**	**% Pred**	**TLC =**	**L**	**% Pred**
FVC =	**L**	**% Pred**	**RV =**	**L**	**% Pred**
DLCO Adj Hb =		**mL/min/mmHg** **%Pred**	**KCO =**	**ml/min/mmHg/L**	**%Pred**

Microbiology

Please attach the last 12 months of sputum results:

Results attached ☐ Yes ☐ No

Have the following organisms ever been isolated?

Burkholderia cepacia	☐ Yes ☐ No	date:	…
Pan-resistant Pseudomonas	☐ Yes ☐ No	date:	…
Scedosporium	☐ Yes ☐ No	date:	…
Mycobacteria (TB or NTM)	☐ Yes ☐ No	date:	…
Aspergillus	☐ Yes ☐ No	date:	…

Prev. Haemoptysis ☐ Yes ☐ No
Details: …
Prev. Pneumothorax: ☐ Yes ☐ No
Details: …
Prev. Thoracic Surgery: ☐ Yes ☐ No
Details: …
Type of Pleurodesis:

Medical History Please complete all sections

Current or previous :			Details:
Stroke	☐ Yes	☐ No	…
Heart Disease	☐ Yes	☐ No	…
Renal Disease	☐ Yes	☐ No	…

If Yes, Last Creatinine: … **Date** … **Last Urea:** …**Date:** …

Liver Disease	☐ Yes	☐ No	…
Diabetes	☐ Yes	☐ No	

If Yes, ☐ **T1DM** ☐ **T2DM** **On Insulin** ☐ Yes ☐No **Recent HbA1c:**

GI Disease	☐ Yes	☐ No	…

Any Other relevant History ☐ Yes ☐ No

Details …

Clinical Assessment (Please complete all sections)

Weight …kgs **Height** …m **BMI*** …

If BMI > 35 not appropriate for referral. If BMI <18 please refer to local Dietician.

Cyanosed	☐ Yes	☐ No	**Respiratory rate**	… (bpm at rest)
Lymphadenopathy	☐ Yes	☐ No	**Oxygen Saturation**	…% on AIR
Clubbed	☐ Yes	☐ No	**Blood pressure**	…mmHg

Heart rate …bpm ☐ regular ☐ irregular ☐ paced

Oxygen at home ☐ Yes ☐ No

If Yes; Requirements …Litres at rest …Litres on exertion

Method … (Np/Hudson mask etc)

Current Exercise Capacity (Objective assessment)

Formal 6 minute walk test

Max distance … metres Lowest saturation …%

Performed on air / oxygen - If Oxygen … litres per minute

Requires Wheelchair ☐ Yes ☐ No

Currently performing Pulmonary Rehab ☐ Yes ☐ No **Dates and Details:**

If No, please refer to local Pulmonary Rehab Program for initial assessment

Allergies:

Current Medication (list or attach print out)

Drug name	Strength	Dose / frequency / special

Family and Social History (Please complete all sections)

Family support available: Nominated primary support person

Known to Social Worker: ☐ Yes ☐ No

If Yes, Name: … Contact details: …

Accommodation (please circle): ☐ **Own** ☐ **Rented** ☐ **Staying with relatives**

Alcohol ☐ Yes ☐ No … Unit per week

Previous heavy alcohol intake ☐ Yes ☐ No

Previous Illicit Drug use ☐ Yes ☐ No …. type

Any significant Family History:

…

…

Psychological assessment Current or Previous History of:

Depression: ☐ Yes ☐ No

Panic attacks: ☐ Yes ☐ No

Anxiety neurosis: ☐ Yes ☐ No

Other Psychiatric conditions: ☐ Yes ☐ No

(If Yes, comment): …

…

Known to Psychiatrist ☐ Yes ☐ No

If Yes, Name: … Contact details: …

Required Investigation / Test Results:

Please ensure the following results are attached and detailed below.

**** To be completed: <12Months of referral**

ECG** Date performed: …

Result: …

Echocardiogram** Date performed: …

Result: …

Chest x-ray** Last performed: …

Result: …

Lung Function (Please attach lung function from the past 2 years)

HRCT Thorax: Date performed: …

– **Films/CD must accompany patient to first visit clinic**

Result: …

…

Arterial Blood Gas ON AIR – (Or state otherwise) Date performed: …

pH: … PO2: : … PCO2: : … BE: : … HCO3: : … SaO2: : …

Others (only if available)

☐ Bone Densitometry Date performed: … Spine T score = … Femur T score= …

☐ Right heart catheter Date performed: …

☐ Coronary Angiogram Date performed: …

Any Other Comments Investigations / Test Results: (detail below or attach)

Signature of Referring Practitioner _____ **Date** _____