ST VINCENT'S HOSPITAL SYDNEY
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

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	

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

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

Current smoker ☐ Yes ☐ No If Yes, please refer to local cessation clinic

(Please note TSANZ guidelines regarding smoking cessation)

Ex-smoker ☐ Yes ☐ No If Yes, Date ceased date: …

Pack Year History date: …

Cotinine level: …

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**

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 …

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:

Clinical Assessment: Please complete all sections

Weight …kgs **Height** …m **BMI*** …

*If BMI >30 or <18 please refer to dietitian

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.

**** Should 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** _____