



Heart Transplant Assessment Referral Form

STRICTLY CONFIDENTIAL

Attention to:

Heart Transplant Physician

Dr: _____

cc The Transplant Assessment Nurse
Heart & Lung Transplant Unit
St. Vincent's Hospital
390 Victoria Street Darlinghurst
Fax: 02 8382 3898

[Email: svhs.transplantreferrals@svha.org.au](mailto:svhs.transplantreferrals@svha.org.au)

Heart Transplant Physicians

Prof Chris Hayward A/Prof Eugene Kotlyar
A/Prof Andrew Jabbour Prof Peter Macdonald
Prof Anne Keogh Dr Kavitha Muthiah

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 heart transplant recipients. As a result, potential transplant candidates can 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 attach all completed investigations and reports to the Transplant Assessment Form.

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

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

Patient / client details:
Name: _____
Date of Birth: / /
Preferred name/s: _____
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss
Medicare No: _____
Elective status: <input type="checkbox"/> Public <input type="checkbox"/> Private
Preferred language: _____

Address: _____
Mobile: _____
Phone: Work: _____
Email: _____
<input type="checkbox"/> DVA <input type="checkbox"/> Work Cover Other <input type="checkbox"/>
Aboriginal/Torres Strait Islander: <input type="checkbox"/> Yes <input type="checkbox"/> No
Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No

Overview referral

...

Cardiac History

Primary Diagnosis: ...

Non Cardiac 1. ...

2. ...

3. ...

Weight: ...kgs **Height:** ...m **BMI*:** ...

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

Current NYHA Class (Please select): 1 2 3 4

Heart rate ...bpm regular paced irregular - **Please attached recent ECG**

Blood pressure: ...mmHg

Respiratory rate: ...bpm **Oxygen Saturation:** ...%

Device Insitu: Yes No

If yes, Date Inserted: ... Health facility where inserted: ...

PPM AICD Brand of Device: ...

Prior EPS studies: Yes No **If Yes, please attached all reports**

Year/s Performed: ...

Prior Coronary Angiogram/CT Coronary Angiogram:

Yes No **If Yes, Please attach all reports**

Year/s Performed: ...

Prior Cardiac Surgery: Yes No

Year/s Performed: ... **If Yes, please attach all reports**

Smoking Status: Current smoker Yes No **If Yes, please refer to local cessation clinic**

Ex-smoker Yes No If Yes, Date ceased: ...

Pack Year History date: ...

Current Serum Cotinine level: ...

Never smoked Yes No

Medical History Please complete all sections

Current or previous :

Details:

Stroke Yes No ...

Respiratory Disease Yes No ...

Renal Disease Yes No ...

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 ...

Family history Bowel Ca Yes No **If Yes, please provide details** ...

Any other relevant history:

...

...

Current Exercise Capacity

Exercise tolerance ... (distance)

Formal 6 minute walk test performed? Yes No

If yes, Max distance ...metres Lowest saturation ...%

Performed on air / oxygen at ... litres per minute

Currently attending Cardiac Rehab Yes No **If No, please refer to a local Cardiac Rehab Program**

<https://svhhearthealth.com.au/Rehabilitation/Overview+of+cardiac+rehabilitation>

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: ...

Known to Social Worker: Yes No

If Yes, Name: ... Contact details: ...

Patients Current Accommodation: Own Rented Staying with relatives

Alcohol Yes No Unit per week: ...

Previous heavy alcohol intake Yes No

Previous Illicit Drug use Yes No Type: ...

Psychological assessment Current or Previous History of:

Depression: Yes No Anxiety neurosis: Yes No

Panic attacks: 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

****Should be completed <12Months of referral**

ECG** Date performed: ...

Echocardiogram** Date performed: ...

Chest x-ray** Last performed: ...

Any prior thoracic imaging: Date performed: ...

All films/CDs and reports must accompany patient to first visit clinic

Overview of imaging results: ...

...

Others Investigations (only if available) please attach results:

Bone Densitometry Date performed: ...

CT Angiogram/Angiogram Date performed: ...

Signature of Referring Practitioner _____ **Date** _____