Mater Misericordiae University Hospital

Ireland Adult Lung Transplantation

Referral Form

Strictly Confidential

This referral has been designed to streamline the referral process for potential lung and heart-lung transplant recipients. As a result potential transplant candidates can be identified more easily and then formally assessed more quickly.
Referral for lung transplant can only be made by consultant respiratory physician only.

Contraindications for lung transplant referral: Active Smoking, BMI > 35

KEY POINTS

1. Please complete all sections - any questions which are not applicable should be marked as N/A
2. When specific results are not available but have been requested please mark as pending.
3. Copies of Imaging that are not available on NIMMS (CT, ultrasound etc) should be sent on CD with this form. **Please include local MRN when done in outside hospital**
4. Copies of complete reports of investigations can be appended to this referral form but the summary must be completed in the appropriate referral section. Serial PFT reports and 6 minute walk reports are very helpful and should be included when available. **Recent ECHO and CT thorax within last 2 years should be included please.**

Any questions about this referral form or its use can be addressed by contacting (01) 8032606 or email lungtransplantreferrals@mater.ie

Please fax the completed form and documents to: (01 8032985) or
Email to lungtransplantreferrals@mater.ie

Please mail CDs of imaging studies
to:

National Heart and Lung Transplant Centre,
Mater Misercordiae University Hospital,
Eccles Street,
Dublin 7

TRANSPLANT REFERRAL

PERSONAL DETAILS							
Patient Name							
Age					Date of birth		
Interpreter Required	Yes		No		Language		
Address							
PostCode							
Telephone Number				Mobile Number			

Referring Consultant					
Name					
Address					
Telephone Number		Fax Number		Email Address	
GP Name					
Address (including Postcode)					
Telephone Number		Fax Number		Email Address	
Is patient aware of referral for transplant assessment	Yes		No		

Respiratory History	
Primary Diagnosis	
Secondary Diagnosis	
Other Diagnosis	1. 2. 3.
Please give history of when and how diagnosis were made:	

Respiratory Diagnoses made by:	Clinical		CT		Histology	
Current Smoker	Yes		No			
Stopped When		Year Pack History				

Microbiology: Have these organisms ever been isolated						
Burkholderia cepacia complex	Yes		No		Date	
Pan-resistant Pseudomonas	Yes		No		Date	
MRSA	Yes		No		Date	
Mycobacteria (TB or atypicals)	Yes		No		Date	
Aspergillus	Yes		No		Date	
Specimen type						
Please list other micro-organisms that are cultured and the dates:						

Oxygen At Home	Yes		No	
PRN Cylinder (Average Daily Use in hours)				
Long term therapy >15 hr daily (Average daily use in hours				

Respiratory Past History				
Haemoptysis	Yes		No	
If Yes Provide Details				
Pneumothorax	Yes		No	
If Yes Provide Details				
PreviousThoracic Surgery	Yes		No	
If Yes Provide Details				
Previous Ventilation	Yes		No	
If Yes Provide Details **(***NIV / formal ventilation in ITU) duration / days*				

Current Exercise Capacity **(Please attach all 6MWT for last 2 years)**				
Exercise Tolerance (Distance)				
Formal 6 minute walk test performed?	**Yes**		**No**	
If Yes Provide	Max distance in metres			
	Lowest saturation %			
Performed on air / oxygen (L/min)				
Wheelchair/ scooter	**Yes**		**No**	
Pulmonary Rehab	**Yes**		**No**	
If Yes Provide Details				

Respiratory Past History / continued

Please describe clinical disease course: Include details on prior treatments for lung disease, approximate start and stop dates, response, rate of decline, life threatening exacerbations and current functional capacity including activities of daily living:

Past Medical History (Please attach relevant clinical letters from Specialists)

Stroke / TIA	Yes		No	
Heart Disease	Yes		No	
Renal Disease	Yes		No	
Liver Disease	Yes		No	
Diabetes	Yes		No	
Peripheral Vascular Disease	Yes		No	
Malignancy	Yes		No	
G.I. Problems	Yes		No	
Thrombo-embolism	Yes		No	
Osteoporosis	Yes		No	
GERD	Yes		No	
Tube Feeding	Yes		No	
Pregnancies	Yes		No	
Chronic Pain	Yes		No	

Others:

Past Surgical History	**Yes**		**No**	

If Yes Provide Details including any previous General Anaesthetics and any issues or known allergies.

Current Medication		
Name	**Dose**	**Frequency**

Known Drug Allergies				Yes		No	
If Yes Provide Details							
Adherences Concerns				Yes		No	
If Yes Provide Details							
Oral Corticosteroids?				Yes		No	
Date Commenced		Max Dose		Current Dose		Dated Stopped	
Response							
Other immunosuppressants received				Yes		No	
If Yes Provide Details below							
Name of Drug		1.					
S/E	Yes		No		Response	Yes	No
Name of Drug		2.					
S/E	Yes		No		Response	Yes	No
Name of Drug		3.					
S/E	Yes		No		Response	Yes	No
Please Provide Details**:**							

Social History				
Martial Status **(**Single, Married, Separated/Divorced, Long-term Partner, Widowed)				
Lives Alone	Yes		No	
If Yes Provide Details				
Alcohol	Yes		No	
Previous Alcohol History	Yes		No	
Recreational / Substance Abuse (Past or Present)	Yes		No	
If Yes to any of the above please give details:				
Relevant Family Medical History:				

Psychological assessment: Current or Previous History of:				
Depression	Yes		No	
Panic Attacks	Yes		No	
Anxiety Neurosis	Yes		No	
Needle Phobia	Yes		No	
Other Psychiatric Conditions.	Yes		No	
If Yes to any of the above please give details:				

Clinical Investigations (Please attach copies if not available on NIMMIS)					
Height Measured		Weight Measured		BMI	
		Date Performed			
ECG					
Result:					
Echocardiogram in last two years (mandatory investigation for referral)					
Result:					
Chest X-Ray					
Result:					
HRCT Thorax in last two years (mandatory investigation for referral)					
Result:					
Bone Densitometry					
Result:					
Abdominal ultrasound:					
Result:					
Coronary angiography:					
Result:					
Right heart catheter:					
Result:					

Of Note:- If results are available on NIMMS please indicate and refer to local MRN

Any Additional Investigations	**Yes**		**No**	
If yes please provide details (Please attach copies)				

Arterial Blood Gases (On Room Air)	
pH	
pO2	
PCO2	
BXS	
HCO3	
Sats	
Other:	

Respiratory Function Tests (Please attach serial PFTs)						
	Date:		**Date:**		**Date:**	
	Value	**% Predicted**	**Value**	**% Predicted**	**Value**	**% Predicted**
FEV1						
FVC						
FEV1/FVC						
TLC						
FRC						
RV						
TLCO						
KCO						

Laboratory Values (Please attach recent bloods)
Please attach: Haematology, Biochemistry, Microbiology and Virology lab results with recent date.
Any other comments and additional information:

Details of Healthcare Professional completing referral form (Consultant / SPR / Registrar only)	
Title / Name (please print)	
Signature	
Date	