South Australian Lung Transplant Unit: Referral Template

Overview:

This form has been designed to streamline the referral process for potential lung transplant recipients. Assessment for Lung transplantation is a complex process, requiring an understanding of the patient's disease trends, current and previous investigations and assessment. The trajectory and synthesis by their current Respiratory Physician is a key component in the triaging and assessment for transplantation. As patients are often significantly functionally limited, we aim to avoid duplication of test results and to maximise efficiency and streamlined assessment. This form contains the minimum information required for Lung Transplant Referral. **In lieu of this form, a specific referral which includes all of the information requested on the form will suffice. NB: Referral to online databases with eg "see letters on EMR" are not sufficient.**

- 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.

Please ensure the items listed below are completed:

Checklist:

o Completed ALL Sections
o Full past medical history & medication list referral letter
o Recent pathology attached (within 4 weeks)
o Cotinine available (Mandatory)
o Patient's chest imaging date and location is included in referral (ie provider and date of most recent imaging) or patient has copy of Chest Imaging for appointment
o Lung Function report (within last 2 years)

All sections need to be completed to assess and appropriately prioritise patients. The patient will receive a phone call or letter regarding a booking if deemed appropriate for Transplant review and assessment. If you have any queries, please contact the SA Lung Transplant Unit on 70742757 to speak to our administrative or clinical staff

Lung Transplant Assessment Referral Form

STRICTLY CONFIDENTIAL

Attention to:

Lung Transplant Physician

Dr:

c/o Department of Thoracic Medicine

8E Blue Space

Royal Adelaide Hospital

Port Road

Adelaide 5000

Referral Date: / /

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

Referring Specialist or stamp:

Name:

Phone:

Fax:

Email:

Address:

Provider number:

General Practitioner details

Name:

Phone:

Fax:

Email:

Address

Provider number

Patient details:

Name:

Address:

Date of Birth:

Preferred name/s:

Mobile:

Medicare No: # DVA Work Cover Other

Interpreter required?: Yes No

Lung Transplant Physicians for pre-transplant assessments:

☐ Professor Mark Holmes

☐ Professor Chien-Li Holmes-Liew

☐ Dr Paroma Sarkar

Overview referral

Respiratory History:

- Primary diagnosis
- Clinical disease course
- Current and prior treatments for lung disease, approximate start and stop dates,
- Response, rate of decline, life-threatening exacerbations etc.

Current In-patient: ☐Yes ☐ No

Hospital admitted at: …

Age:……

Previous Ventilation: ☐ NIV ☐Mechanical Ventilation

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

Smoking status

Currently smoking ☐

Never smoked ☐

Ex-smoker ☐ Pack Year History …… Date ceased: ……..…

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

ABG

Formal 6 minute walk test: Max distance … metres; Lowest saturation ……%; Performed on air / oxygen - If on Oxygen ……. litres per minute

Microbiology

Please attach the last 12 months of sputum results: Have the following organisms ever been isolated? (tick all which apply)

☐ Burkholderia cepacia … date: …

☐ Pan-resistant Pseudomonas ….. date: …

☐ Scedosporium ….. date: …

☐ Mycobacteria (TB or NTM) ….. date: …

☐ Aspergillus ….. date: …

☐ Other relevant organisms ….. 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 …details if yes……

Heart Disease ☐ Yes ☐ No … details if yes……

Renal Disease ☐ Yes ☐ No … details if yes……

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

Liver Disease ☐ Yes☐ No … details if yes……

Diabetes ☐ Yes ☐ No

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

GI Disease ☐Yes ☐ No … details if yes……

Other medical conditions……

……

……

……

……

……

……

……

……

……

Details of specialists managing above conditions …

Clinical Assessment (Please complete all sections)

Weight ……kgs **Height** ……m **BMI*** ……

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: Date commenced……; Requirements …Litres at rest …Litres on exertion

Method … (Np/Hudson mask etc)

Current Exercise Capacity (Objective assessment)

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

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: …

Relevant Investigation / Test Results:

Please ensure the following results are attached and detailed below.

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

Chest x-ray** Last performed: …

Result: …

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

HRCT Thorax: Date performed: …

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: …

ECG** Date performed: …

Result: …

Echocardiogram** Date performed: …

Result: …

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

Signature of Referring Practitioner _____ **Date** _____