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 email to **lungtransplantreferrals@mater.ie**.

Please mail CDs of imaging studies to:
National Heart and Lung Transplant Centre,
Mater Misericordiae University Hospital,
Eccles Street, Dublin 7.

Personal Details

Patient name					
Patient age			**Date of Birth**		
Interpreter required	**Yes**		**No**		**Language**
Patient address					
Post code					
Patient telephone no			**Patient mobile no**		

Referring Consultant

Consultant name					
Consultant address and post code					
Telephone no		**Fax no**		**Email**	
GP name					
GP address and post code					
GP telephone no		**GP fax no**		**GP email**	
Is patient aware of referral for transplant assessment		**Yes**		**No**	

Respiratory History

Primary diagnosis					
Secondary diagnosis					
Other diagnosis					
Please give history of when and how diagnosis was made					
Respiratory diagnosis 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 cepacia complex	**Yes**		**No**		**Date**	
MRSA	**Yes**		**No**		**Date**	
Mycobacgeria (TB or atypicals)	**Yes**		**No**		**Date**	
Aspergillus	**Yes**		**No**		**Date**	
Specimen type						

Please list other micro-organisms that are cultured and the dates	

Oxygen

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				
Previous thoracic 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 two years)**

Exercise tolerance (distance)				
Formal 6 minute walk test performed	Yes		No	
If yes, please 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	
GI problems	Yes		No	
Thrombo-embolism	Yes		No	
Osteoporosis	Yes		No	
GERD	Yes		No	
Tube feeding	Yes		No	
Pregnancies	Yes		No	
Chronic pain	Yes		No	
Other (please give details)				

Surgical History

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		Date stopped	

If yes, provide response				
Other immune-suppressants received	Yes		No	
If yes, provide details below				
Name of drug				

S/E	Yes		No		Yes		No	

Name of drug	

S/E	Yes		No		Yes		No	

Name of drug	

S/E	Yes		No		Yes		No	

Provide details	

Social History

Marital 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 provide 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 provide details				

Clinical Investigations (Please attach copies if not available on NIMMIS)

Height measured		Weight measured		BMI	
ECG		Yes		No	
Date Performed					
Result					
Echocardiogram in last two years (mandatory investigation for referral)		Yes		No	
Date Performed					
Result					
Chest X-ray		Yes		No	
Date Performed					
Result					
HRCT Thorax in last two years (mandatory investigation for referral)		Yes		No	
Date Performed					
Result					
Bone densitometry		Yes		No	
Date Performed					
Result					
Abdominal ultrasound		Yes		No	
Date Performed					
Result					
Coronary angiography		Yes		No	
Date Performed					
Result					

Right heart catheter	Yes		No	
Date Performed				
Result				

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

Additional Investigations (Please attach copies)

Any additional investigations	Yes		No	
If yes, please provide details and attach copies				

Arterial Blood Gases (on room air)

pH	
pO2	
PCO2	
BXS	
HCO3	
Sats	
Other	

Respiratory Function Tests (Please attach copies)

	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

(Consultant / SPR / Registrar only)

Title and name (please print)	
Signature	
Date	