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

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.heartlungclinic@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: ☐ Male ☐ Female
Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss
Medicare No:
Elective status: ☐ Public ☐ Private
Preferred language:

Address:
Mobile:
Phone: Work:
Email:
☐ DVA ☐ Work Cover Other ☐
Aboriginal/Torres Strait Islander: ☐ Yes ☐ No
Interpreter required? ☐ Yes ☐ 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** _____