

## **INTERSTATE INTESTINAL TRANSPLANT REFERRAL - Form 1**

### **Local referring centre to complete**

| <b>Referrer details</b> |  |
|-------------------------|--|
| Referrer name           |  |
| Referring Hospital      |  |
| Referrer Phone/ Mobile  |  |
| Email                   |  |
| Date of referral        |  |

| <b>Patient details</b>                 |  |
|--|--|
| Patient name                           |  |
| DOB                                    |  |
| Age and sex                            |  |
| Address                                |  |
| Local UR no.                           |  |
| RCH UR no. (if applicable)             |  |
| Medicare no. & expiry                  |  |
| Patient contact details & relationship |  |
| Height, and centile                    |  |
| Weight, and centile                    |  |

| <b>Underlying Diagnosis</b>  |   |  |
|--|---|--|
|  |   |  |
| <b>Indications for Intestinal Transplant:</b><br>TPN dependent AND irreversible intestinal failure with at least one of following: |   | <b>Details</b>   |
| End-stage liver disease, or impending  | Y <input type="checkbox"/> N <input type="checkbox"/> | <i>(please provide following: INR, Total bilirubin, albumin level, platelet count, and any other relevant information)</i> |

|  |   |  |
|--|---|--|
| Loss of central line access (>2 major veins)                 | Y <input type="checkbox"/> N <input type="checkbox"/> | <i>Patency of:</i> LIJ Y <input type="checkbox"/> N <input type="checkbox"/> RIJ Y <input type="checkbox"/> N <input type="checkbox"/><br>LSC Y <input type="checkbox"/> N <input type="checkbox"/> RSC Y <input type="checkbox"/> N <input type="checkbox"/><br>LCF Y <input type="checkbox"/> N <input type="checkbox"/> RCF Y <input type="checkbox"/> N <input type="checkbox"/><br><i>Site of current line:</i> |
| Severe sepsis/ line infections (2 or more episodes per year) | Y <input type="checkbox"/> N <input type="checkbox"/> | Details and dates:   |
| Frequent episodes severe dehydration                         | Y <input type="checkbox"/> N <input type="checkbox"/> | Details and dates:   |

| <u>Contraindications for Intestinal Transplant</u>   |   | Details |
|--|---|---------|
| Metastatic cancer                                    | Y <input type="checkbox"/> N <input type="checkbox"/> |         |
| Ongoing/ recurrent infections resistant to treatment | Y <input type="checkbox"/> N <input type="checkbox"/> |         |
| Significant cardiac/ pulmonary conditions            | Y <input type="checkbox"/> N <input type="checkbox"/> |         |
| Demonstrated patient non-compliance                  | Y <input type="checkbox"/> N <input type="checkbox"/> |         |
| Other:   | Y <input type="checkbox"/> N <input type="checkbox"/> |         |

| Other information: |
|--------------------|
|                    |

**If patient has:**

- *One or more indications for intestinal transplant; and*
- *No contraindications to intestinal transplant*



**Patient is a potential candidate for intestinal transplant**

*(Note: we welcome medical suitability discussion for patients with possible contraindications)*



**Send referral letter and this completed form to:**

*A/Professor Jason Yap  
The Royal Children's Hospital (Melbourne)*



**On receipt of referral, RCH will contact referring physician for initial telephone discussion (physician to physician) regarding patient suitability**