The Royal Children's Hospital Melbourne
50 Flemington Road
Parkville Victoria 3052 Australia
TELEPHONE +61 3 9345 5522
www.rch.org.au

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INTERSTATE INTESTINAL TRANSPLANT REFERRAL - Form 2

1. Local referring centre to complete and forward to RCH prior to TELEHEALTH CONSULTATION
2. Content to be reviewed during telehealth consult

TELEHEALTH CONSULTATION - phone consultation details	
Referrer name	
Referring Hospital	
Referrer Phone/ Mobile	
ATTENDEES AT REFERRAL HOSPITAL during consultation:	
ATTENDEES AT RCH during consultation:	
Date & time of call (telehealth consultation)	

1. Patient details	
Patient name	
DOB and age	
Local UR no.	
RCH UR no.	

2. Allergies

3. Underlying Diagnosis

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4. Past surgical history (including non GI surgery)

TELEHEALTH CONSULTATION NOTES:

5. Medication list

TELEHEALTH CONSULTATION NOTES:

6. Bowel Assessment

Small intestine	*Length:*
Colon	*Function:* *Colonoscopy:* *Histology:*
ICV present?	
Stoma and location	
Gastric tube, type	

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Jejunal tube	
Other tubes	
Bowel continence?	
Function and Anatomy Studies (results and dates if done, please attach)	
Motility	*Antroduodenal manometry:* *Colonic manometry:* *Other manometry:* *Gastric emptying (nuclear medicine):*
Barium meal and follow-through contrast study	
History of dysphagia?	
Other radiological studies	
Gastroscopy/ enteroscopy	*Report:* *Histology:*
Small bowel histology	
TELEHEALTH CONSULTATION NOTES:	

7. Nutritional assessment	
Height, centile (CDC 2-20) *(date of measure)*	
Weight, centile (CDC 2-20) *(date of measure)*	
Growth and Anthropometry	see below

Measurements (cm)	Date:	Date:	Date:
MUAC			
Skin folds			
Head circumference			

BMI:
Growth failure?:
Copy of growth charts:

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Estimated Energy Requirements	
Caloric intake percentage	*PN:* *EN:*
Working weight for PN	
PN	*Prescription (attach from BAXTER):* *Total volume per day:* *Rate of administration (including grading up/down):* *Lipid type:* *Lipid gm/kg/d:*
Enteral	*Type:* *Concentration:* *Total volume per day:* *Rate/ method of administration:*
Other fluids given *(IV/ enteral, reason)*	
Oral intake per day	*Solid:* *Liquid:* *Fluid restriction:* O**ral aversion** *?*:
Measured output per day	*Stoma (volume and description):* *PR (volume and description Bristol stool):* *Vomiting (volume and description):* *Other (volume and description):*
CVAD lock/flush regime	
Other information:	

TELEHEALTH CONSULTATION NOTES:

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8. Liver Assessment	
Liver biopsy histology	
Signs of portal hypertension?	Doppler ultrasound: Spleen size: Hypersplenism: Ascites: PV flow: Oesophageal varices: History of spontaneous bleeding?: Other varices:
Portal vein pressure measurements	
Fibroscan	
Bloods	

	Date	Result	Date	Result
Haemoglobin				
Platelets				
WCC				
Neutrophils				
Lymphocytes				
INR				
PT				
APTT				
Fibrinogen				

	Date	Result	Date	Result
Bilirubin Total				
Bili Conjugated				
ALT				
AST				
ALP				
GGT				
Total Protein				
Albumin				
Ammonia				

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TELEHEALTH CONSULTATION NOTES:

9. Vessel patency	(Yes/No)	Comments, method of assessment: (please attach reports and send CD of images)
RIJ		
RSC		
RBC		
LIJ		
LSC		
LBC		
RCF		
LCF		
SVC		
IVC		
Other		

10. Venous assessment	
Current access	
Previous infections	
TELEHEALTH CONSULTATION NOTES:	

11. Psychosocial status	
Social situation (eg. parental/ carer situation	

including employment status, siblings, etc.)	
Community supports	
Engagement with hospital	
Compliance (child & family)	
School attendance	

TELEHEALTH CONSULTATION NOTES:

12. Other information:
TELEHEALTH CONSULTATION NOTES:

TELEHEALTH CONSULTATION:

1. Additional Notes:

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2. Decision:	
Suitable for further assessment:	**NO:** **If patient unsuitable for further assessment:** **1.** *Letter to be written by RCH to referring physician regarding reasons for decision and other recommendations* **2.** *If suitable for re-referral at later stage, detail reasons and process*
	YES: **If patient suitable for further assessment:** **1.** *Letter to be written by RCH to referring physician regarding reasons for decision and notes from consultation.* **2.** *RCH to provide 'Interstate Intestinal Transplant Referral - Form 3' to referring hospital to complete* **3.** *RCH to provide list of additional investigations patient requires, (eg. specific imaging, VTIS bloods)* **4.** *Referring hospital to complete 'Form 3' and additional investigations requested, and forward all results to RCH* **5.** *RCH to review all results once received, and discuss with transplant team at multi-disciplinary meeting to decide suitability for ongoing assessment/ work-up at RCH*

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