

Liver Care Clinic Referral Form

(Decompensated Liver Disease Clinic)



Date of referral: _____

Demographics (Please complete or place patient label)

Name: _____ DOB: _____ PHN: _____

MRN: _____ Phone Number: _____ Address: _____

Email Address: _____ Alternate Contact Name: _____ Contact Phone: _____

Reason for Referral (select all that apply):

- ☐ Assessment, Monitoring and Medical Management
- ☐ Urgent Therapeutic paracentesis

NOTE: We are not accepting referrals for patients with ascites secondary to malignancy.

Wait times for assessment for urgent referrals will usually be 3-5 days from receipt of referral.

If more urgent assessment needed (e.g. if paracentesis required within 24-48hrs) please contact the on call Liver Clinic physician between 9am-5pm, Mon-Fri. Contact details available on intranet on call schedule and through switchboard

Criteria (Check all to indicate fulfilled criteria):

- ☐ Diagnosis of cirrhosis or acute hepatitis
- ☐ One or more of the following decompensation events in the last 30 days (Check all that apply)
 - ☐ Ascites
 - ☐ Hepatic Encephalopathy
 - ☐ Variceal Bleed
 - ☐ Hepatorenal syndrome
 - ☐ Hepatopulmonary syndrome.
 - ☐ Spontaneous bacterial peritonitis
 - ☐ Acute alcoholic hepatitis
- ☐ Have had the following blood work done within 7 days of this referral
 - ☐ CBC, electrolytes, Cr, Urea, INR, total bilirubin, ALT, AST, GGT, ALP, Albumin.

Referral Source: _____

Referring Physician/Nurse Practitioner Name: _____ **MSP:** _____

Other Relevant Information (Please include clinic letters/ED notes/ discharge summary with referral):

Liver Care Clinic

Royal Block Level 1, Royal Jubilee Hospital 1952 Bay St, Victoria, B.C. V8R1J8

Fax: 250-370-8186

Phone: 250-370-8220