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| **Advanced Chronic Liver Disease MDM Referral form** **Please note all fields are MANDATORY****Incomplete referrals will be returned****Email completed forms to** kch-tr.acldreferrals@nhs.net |
| **Referrer Details** |
| **Referrer**\*  | **Click here to enter text.**  | **Date**\* |  **Click here to enter text.** |
| **Referrer Contact Tel and Extension**\* | **Click here to enter text.** | **Consultant Name**\* |  **Click here to enter text.**  |
| **Referrer Email**\* | **Click here to enter text.** | **Consultant Email\*** | **Click here to enter text.** |
| **Speciality**\* | **Click here to enter text.** | **Hospital/Site** \* |  **Click here to enter text.**  |
| **Patient Details** |
| **Patient Name**\* |  **Click here to enter text.**  | **Currently**\* | **Inpatient** [ ] **Outpatient** [ ]  |
| **Date of Birth\*** |  **Click here to enter text.**  |
| **NHS Number**\* |  **Click here to enter text.**  | **Patient Mobile Tel**\* | **Click here to enter text.** |
| **Patient gender**\* | **M** [ ]  **F** [ ]  **Other** [ ]  | **Patient home Tel**\* | **Click here to enter text.** |
| **Patient Address and** **Postcode**\* |  **Click here to enter text.**  | **NOK Name/Tel.**\* | **Click here to enter text.** |
| **Interpreter Required?**\**If* ***yes****, language spoken:* | **Y** [ ]  **N** [ ]  |
| **GP Address and postcode\*** |  |  |  |
| **Is patient aware of referral to King’s?**\* | **Y** [ ]  **N** [ ]  | **(We would strongly recommend ensuring the patient is made aware of this referral)** |
| **Indication for Referral** |
| **What is the question for the ACLD MDM?**\***Click here to enter text.** |
| Choose an item.**Click here to enter text.** |
| **Clinical history**\* |
| **Click here to enter text.** |
| **Aetiology of Liver disease**\* |
| Alcohol [ ] MASLD/NAFLD [ ] Viral Hepatitis [ ]  | PBC or PSC or Autoimmune hepatitis [ ] A1AT [ ] Haemachromatosis [ ] Wilsons Disease [ ]  | Unknown[ ]  Secondary biliary cirrhosis[ ] Vascular Liver Disease[ ] Non-cirrhotic portal hypertension [ ]  |
| **Current issues**\* |
| **If refractory ascites*** Is patient diuretic-intolerant (hypoNa /renal dysfunction): **Choose an item.**
* Is patient diuretic-refractory (on maximal doses): **Choose an item.**
* Frequency of drains and over what time period:

**Click here to enter text.*** Average volume drained at LVP

**Click here to enter text.*** Previous SBP?
* Ascitic fluid results: Yes [ ]  No[ ]

**Click here to enter text.****If refractory hepatic encephalopathy*** Has the patient had HE previously? Yes [ ]  No[ ]
* If yes, please provide details

**Click here to enter text.****If refractory/recurrent portal HTN-related bleeding** – please provide details:**Click here to enter text.** |
| **Alcohol and drug use**\* |
| **Is the patient currently consuming alcohol?** Yes [ ]  No[ ] **Click here to enter text.**If so, please attempt to quantify:**Click or tap here to enter text.****If abstinent, since what date *(not duration)*?** **Click here to enter text.**Are they engaged with community alcohol services? Yes [ ]  No[ ] **Click here to enter text.**Do they use/have a history of recreational drug use? Yes [ ]  No[ ] **Click here to enter text.** |
| **Past medical history**\* |
| None [ ] Ischaemic heart disease [ ] Previous CABG/Cardiac Stent [ ] AF [ ] Heart Failure [ ] HTN [ ]  | Diabetes Hyperlipidaemia [ ] Obesity [ ] Asthma [ ] COPD [ ] TIA/CVA [ ] CKD [ ]  | Osteoporosis [ ] Active cancer (please state management plan and Oncological prognosis [ ] **Click or tap here to enter text.**Previous cancer (dates included) [ ] **Click or tap here to enter text.** |
| Other past medical history**Click or tap here to enter text.** |
| Is the patient being worked up for any other procedures currently? Choose an item.If so please specify. **Click or tap here to enter text.** |
| **Past surgical history**\* |
| **Click or tap here to enter text.** |
| **Current medications:**\* |
| **\*Please ensure you include the name of medication, dosage and frequency.** |
| **Allergies:** Yes [ ]  No[ ] **If yes please specify: Click or tap here to enter text.** |
| Performance Status (0-4)\*: **Click Here** |
| **Nutrition:****(weight, height, BMI etc.)** | **Nutritional status:**  Click here to enter text.**Weight:** Click here to enter text.**Height:** Click here to enter text.**BMI:**  Click here to enter text. |

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| **INVESTIGATIONS** |
| Bloods\* | Date: |  |  |  |  |  |
| Bilirubin |  |  |  |  |  |
| ALT |  |  |  |  |  |
| AST |  |  |  |  |  |
| ALP |  |  |  |  |  |
| GGT |  |  |  |  |  |
| Albumin |  |  |  |  |  |
| AFP |  |  |  |  |  |
| Sodium |  |  |  |  |  |
| Creatinine |  |  |  |  |  |
| eGFR |  |  |  |  |  |
| Hb |  |  |  |  |  |
| Platelets |  |  |  |  |  |
| INR |  |  |  |  |  |
| HbA1c |  |  |  |  |  |
| **CIRRHOSIS SEVERITY AND PROGNOSTIC SCORES**\* | **MELD Score:** Click here to enter text.**UKELD Score:** Click here to enter text.**Child-Pugh Score:** Click Here |
| **IMAGING** | **Date of Scan(s)** | **Report**  |
| **Liver ultrasound** | Click here to enter text. | Click here to enter text. |
| **CT CAP** **(with liver vascular imaging biphasic/triphasic)** | Click here to enter text. | Click here to enter text. |
| **MRI Gad or Primovist** | Click here to enter text. | Click here to enter text. |
| **Other relevant imaging** | Click here to enter text. | Click here to enter text. |
| **PATHOLOGY & OTHER INVESTIGATIONS** |
| **Histology:**  | Click here to enter text. | Click here to enter text. |
| **Endoscopy:**  | Click here to enter text. | Click here to enter text. |
| **FibroScan:**  | Click here to enter text. | Click here to enter text. |
| **EEG:**  | Click here to enter text. | Click here to enter text. |
| **Echocardiogram** | Click here to enter text. | Click here to enter text. |