

April 27, 2001

ORGAN TRANSPLANTS

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy to ensure equal access to organ transplants in the Department of Veterans Affairs (VA) and guidance to all VA medical centers and outpatient clinics on transplantation procedures and funding policies.

2. BACKGROUND: Organ transplantation through VA is performed as a National Referral System. VA has offered transplant services since 1961. Approximately 8,000 veterans have been transplanted through the VA referral system. VA has an active transplant program that can accommodate all eligible veterans.

3. POLICY: It is VHA policy that the provision of organ transplantation will continue to eligible veterans following the procedures defined in this Directive.

4. ACTION

a. **Eligibility.** All veterans enrolled for care in the VA system are eligible for transplant services. The Chief, Health Administration Service (HAS), or equivalent, must complete and sign Part B of VA Form 10-0390, VA Transplant Referral Form, dated March 2000, thereby certifying the patient's eligibility for care, treatment, and travel. A printout of the patient's eligibility information must be attached to each referral.

b. Referral Process

(1) The request for a solid organ (organ) or bone marrow/peripheral stem cell (bone marrow) transplant **must** originate from the veteran's primary VA medical center where the patient is enrolled. The VA staff physician who made the referral is responsible for ensuring that complete, accurate, and current information is included in the referral packet. A referral packet consists of a completed Referral Form (see Att. C) and all required documentation (see Atts. A and B). The VA staff physician making the referral and the Chief of Staff (COS), or clinical equivalent, must sign the Referral Form and include a VA telephone number, VA fax number, and a VA e-mail address. The name, telephone number, fax number, and an e-mail address of a contact person at the VA medical center must also be included. The Referral Form must be typed or printed legibly. **The original referral packet and three copies** should be mailed, preferably by overnight mail, to the VA National Transplant Program Office (Transplant Office) at the address listed on the Referral Form. The VA medical center must **not** mail the referral packet directly to a VA Transplant Center (VATC).

(2) All sections of Part I of the Referral Form **must** be completed. Copies of all required reports and laboratory data must be provided. Complete and recent clinical information is important so that informed decisions can be made. There must be a concise referral letter from the VA staff physician (see Att. A, par. 1) and a thorough psychological and social evaluation (see Att. A, par. 3). Referrals will not be processed without the referral letter from the VA staff

VHA DIRECTIVE 2001-027

April 27, 2001

physician. The entire referral packet, with the referral letter, should seldom exceed 20-25 pages.
NOTE: *Do not photocopy the entire medical chart.*

(3) If there is a preference for using a certain VATC, it should be indicated on the first page of the Transplant Referral Form under Referring Physician's Notes. If feasible, every effort will be made by the Transplant Office to accommodate the request.

NOTE: *Required information must be provided. Incomplete referral packets will result in a delay in getting the referral to the appropriate organ-specific Transplant Review Board (Board) while the missing information is sought from the requesting facility. If there are any questions or if this is the first time the physician is making a referral, contact the COS's office or the Transplant Office prior to submitting the referral packet. Transplant Office telephone numbers are listed on the Referral Form.*

(4) A referral packet received by the Transplant Office will be reviewed to ensure that the Referral Form is complete and all required information is included and current. A correctly submitted referral packet will be sent to two Board members. If the referral packet is incorrectly submitted, the contact person at the VA medical center will be notified so the discrepancies can be corrected. The COS will be informed that a request for information has been made. If there is no response or follow-up from the contact person within seven days, the COS will be notified again, and the Network Clinical Manager will also be notified. **NOTE:** *The referral packet will not be sent for review until the discrepancies are corrected.*

(5) If additional information is needed by a Board member in order to make a recommendation, the Transplant Office will notify the contact person at the VA medical center. The COS will be informed that a request for information has been made. If there is no response or follow-up from the contact person within seven days, the COS will be notified again, and the Network Clinical Manager will also be notified. The Board action will be deferred until the information is received.

(6) Based upon the recommendations of the Board, the final decision as to whether a patient is a candidate for an in-person evaluation at the VATC is made in the Transplant Office. If there is not an agreement between the two Board members, a copy of the referral packet is sent to a third, and in some instances a fourth, Board member. The referring VA staff physician and COS will be informed of the Board's final decision. The Transplant Office will also notify the VATC if an assignment is made. If the patient is not accepted as a candidate for an in-person evaluation at a VATC, VA cannot offer transplant services. The Chief Consultant, Acute Care Strategic Healthcare Group, or a physician designee in the Transplant Office, will sign the decision when the patient is not a candidate. Patients are free to seek additional opinions; however, VA will not be financially liable for the cost of the additional opinions or any transplant performed without VA referral and approval. The referring VA staff physician should personally communicate the final decision to the patient and/or the patient's family.

(7) After assignment, if the VATC requires additional information, the request will be directed to the contact person at the VA medical center. **NOTE:** *It should be emphasized that approval by the Board only guarantees that the patient will undergo final evaluation at a*

Transplant Center. The evaluation at the VATC will determine the veteran's eligibility for a bone marrow transplant or for listing on the United Network for Organ Sharing (UNOS) waiting list for an organ transplant. If, after final evaluation by the assigned VATC, the patient is not accepted as a candidate, the VATC is to notify, in writing, the VA staff physician and COS at the VA medical center and the Transplant Office.

(8) If the VA staff physician and/or patient is dissatisfied with either the decision of the Transplant Office or the VATC, the staff physician must submit a detailed letter to the Transplant Office explaining why the case should be reconsidered. If there is supporting documentation, it must be submitted with the letter.

(9) If a retransplant is necessary within nine months after the patient has been discharged from the transplant center back to the VA medical center, the VA medical center is responsible for submitting an abbreviated referral packet to the Transplant Office. The Transplant Office should be contacted for guidance. After the 9-month period, a complete referral packet is required.

NOTE: With advance planning and adherence to this Directive on the part of VA medical centers, the vast majority of transplants can be accommodated on a non-emergent basis.

c. **Pre-Transplant Dental Treatment**

(1) Some dental infections or intraoral diseases compromise the medical treatment of many transplants. It is imperative for each VA medical center to establish local protocols to ensure identification, evaluation, and necessary dental treatment of veterans with specific medical conditions including pre-transplant evaluations.

(2) The COS at the VA medical center with primary responsibility for a patient being referred for an organ or bone marrow transplant should ensure that the patient is provided the opportunity for Dental Service to evaluate and provide needed dental therapy. Physician and dentist members of the medical staff should coordinate the identification, referral, consultation and interdisciplinary management of these patients. *NOTE: Authority to do so is found in G-2, M-4 (October 1990) "Inter-disciplinary Management of Patients Having Medically Compelling Needs for Dental Treatment," and in Handbook 1130 (Dentistry) under the eligibility section (subpars 5c(2)(a) and 6c(1)(f) and (i).*

(3) The dental treatment plan should ensure that foci of oral infection are eliminated or treated prior to transplant or before transfer to the transplant facility. In addition, a dental evaluation and assessment should be accomplished for all post-transplant patients at an appropriate time.

d. **Emergency Referrals**

(1) An emergency is defined as a referral of an inpatient with a prognosis of very short-term survival who may be too unstable to be transferred to a VATC. Most emergency referrals are made to a locally contracted transplant center.

VHA DIRECTIVE 2001-027

April 27, 2001

(2) In cases when an emergency referral needs to be made, the Transplant Office should be notified by telephone as soon as that determination is made by the VA medical center. Once telephonic notification has been made, the emergency referral packet can be faxed to the Transplant Office. The emergency referral packet must include the Referral Form, physician referral letter, eligibility information, blood type, and as much clinical information as is available from the current admission. If possible, a thorough psychological and social evaluation should also be included. The original referral packet should be sent by overnight mail. If time allows, the Transplant Office contacts two Board members and the referral packet is faxed to them. The Board members either telephone or fax their response to the Transplant Office. If time does not allow transmittal of the emergency referral packet to the Board members, the Chief Consultant, Acute Care Strategic Healthcare Group, or physician designee, will act on the request.

(3) If the patient stabilizes and can be transported, or is discharged from the hospital (either VA medical center or local contracted transplant center), the Transplant Office should be notified and a reassignment will be made to a VATC.

e. Patient Follow-up

(1) The VA's transplant experience identifies an absolute need for follow-up by appropriately trained transplant experts. The COS, in consultation with the VA staff physician, needs to make arrangements for patient follow-up. The VA staff physician may wish to discuss this with the post-transplant coordinator at the VATC where the transplant was performed. The COS may have to identify appropriate local non-VA expertise to provide the necessary continuity of care. This care would be paid for by the VA medical center. In addition, annual follow-up visits may be required by the VATC.

(2) All follow-up care, medications, and travel to the VATC are at the expense of the VA medical center.

(3) The VA medical center is responsible for informing the Transplant Office if a patient:

(a) Relocates and transfers care to a different VA medical center,

(b) Decides not to pursue a transplant through the VA national referral system, or

(c) Expires.

f. **Funding**

(1) **Contracts**

(a) Contracts are used to accommodate emergency patients, usually for a heart or liver transplant. These are patients who, for medical reasons, cannot be transported to, or accommodated by, a VATC. VA medical centers are encouraged to establish such contracts for backup purposes, but the contract should be established for only one to two procedures per year, and the affiliate must be a member of the Organ Procurement and Transplantation Network (OPTN).

(b) Contracts are not to be used on a routine basis as an alternative to transplant at a VATC by any VA medical center. In the case of a medical emergency or other extenuating circumstances, the COS may request use of the local contract. In these instances, the COS should provide a written explanation to the Transplant Office in support of the request. This explanation should accompany the referral packet. The Transplant Office will make the final decision as to whether the contract will be used. If a VA medical center uses the contract for such purpose without getting prior approval from the Transplant Office, the Transplant Office will not be responsible for the cost of the transplant. **NOTE:** See *subpar. 4d*.

(c) Use of such contracts by the Transplant Office requires that:

1. The patient must be declared a candidate by the appropriate VA transplant organ-specific Board,

2. The VATC programs must be unable to accommodate the patient, and

3. A contract must be in place using the Emergency Organ Transplant Statement of Work template on the VHA Logistics Office Website (<http://vhacoweb1.cio.med.va.gov/logistics>).

(d) If all of these conditions are met, the Transplant Office may assign the patient to the VA medical center's contracted facility at the Transplant Office's expense for the rate-per-case stated in the contract. If the case is not assigned by the Transplant Office to the local contracted facility, the VA medical center will be fiscally responsible for the transplant. For Transplant Office-approved local assignments, all expenses other than the rate-per-case are the responsibility of the VA medical center.

(2) Transplants are centrally funded if performed at a VATC, if the Transplant Office directed the assignment to a sharing agreement site, or if under an approved emergency contract. The VATC is responsible for those aspects of pre-transplant care, which include the initial evaluation and subsequent evaluations, until time of admission for the transplant episode. All other care provided by the VATC that is not part of the pre-transplant, e.g., ventricular assist devices (VAD), chemoembolization, dental, etc., are the fiscal responsibility of the VA medical center. Post-transplant care begins when the patient is discharged from the VATC back to the VA medical center. The VA medical center is responsible for matching, typing and search costs

VHA DIRECTIVE 2001-027

April 27, 2001

for unrelated bone marrow transplants. The Transplant Office funds harvest costs for unrelated bone marrow transplants.

(3) Critical care transportation or other transportation costs, at any time before or after the transplant, are the responsibility of the VA medical center. There may be circumstances when a transplant candidate on the waiting list needs to have emergency transportation to the VATC when an organ becomes available. The attending VA physician and the VATC should make this decision. The VA medical center is responsible for the cost of the emergency transportation.

(4) Round-trip transportation of the patient to the assigned transplant center will be paid by the VA medical center. Round-trip travel for a support person, and/or donor in the case of a bone marrow or kidney transplant, is also funded by the VA medical center. **NOTE:** *For pre-transplant appointments for initial and interim evaluations and post-transplant follow-up that may be required of the patient, the support person and/or donor travel will be paid by the VA medical center. All allogeneic bone marrow transplant patients and non-kidney organ recipients are expected to return to their VATC annually on their transplant anniversary for a full evaluation. This travel is also paid by the VA medical center.*

(5) There are cases where the VA medical center that referred the patient for transplantation is no longer responsible for the patient's transplant costs. If a patient relocates and care is transferred to a different VA medical center, the new VA medical center becomes the primary VA medical center and is responsible for present and future expenses related to the transplant.

(6) The Transplant Office will fund temporary lodging for the patient and one support person, and a donor when needed. The only exception is if the patient has children (18 years old or younger) who must accompany the patient and support person due to lack of childcare or adult supervision at home. In those situations, the Transplant Office will fund lodging. Temporary lodging is used at the time of initial evaluation, any follow-up evaluations prior to or while on the waiting list, at the time of the transplant episode until discharge to home from the VATC, and any post-transplant follow-up visits. There may be instances when the patient must remain in the area of the transplant center while waiting for an organ. This is also considered temporary lodging. **NOTE:** *The Transplant Office will not support lodging if the patient and family decide to permanently relocate to the area in which the VATC is located.*

(7) Patients who have been approved by the Transplant Office for a heart transplant may require implantation of a VAD as a bridge to transplant. This surgery is performed at the VATC and the patient remains hospitalized while waiting for a heart to become available. This is considered medical care and not part of the transplant episode. The VA medical center is fiscally responsible for the surgery and subsequent hospitalization. The VATC will make arrangements with the VA medical center for the provision of this care. A VAD is classified as a Prosthetic Surgical Implant and will be charged to the VA medical center's Sub-account 2692 – Prosthetic Supplies, Cost Center 202.

(8) When a renal transplant is required for a VA patient and a suitable donor (veteran or non-veteran) is available, the donor will be hospitalized on the same basis as the potential recipient. Centralized funding will be provided for the identified donor's evaluation and procedure. The

VA medical center is responsible for the donor's travel when necessary, and for re-hospitalization for any necessary after-care related to the surgical procedure or to the loss of the donated kidney.

(9) When the transplanted patient is discharged back to the VA medical center, it is then the VA medical center's responsibility, using the VA National Formulary, to provide all medications for the patient. The transplant center is only responsible for medications needed during the transplant hospitalization and post-transplant stay.

5. REFERENCES

- a. VHA Directive 2001-004, Funding of Left Ventricular Assist Devices.
- b. Interdisciplinary Management of Patients Having Medically Compelling Needs for Dental Treatment, Program Guide, VA Manual G-2, M-4, October 1990 (Revised) and Handbook 1130.
- c. M-2, Part XIV, Change 22, May 6, 1975 – Chapter 7. Renal Disease Treatment Program —Transplantation, Sec. 7.02, e.

6. FOLLOW-UP RESPONSIBILITY: Chief Consultant, Acute Care Strategic Healthcare Group (111), is responsible for the content of this Directive.

7. RESCISSION: VHA Directive 10-95-074 is rescinded. This VHA Directive expires April 30, 2006.

S/ by Dennis H. Smith for
Thomas L. Garthwaite, M.D.
Under Secretary for Health

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ATTACHMENT A

**GENERAL INFORMATION REQUIRED FOR ALL SOLID ORGAN
AND BONE MARROW TRANSPLANT REFERRALS**

1. All referrals require a concise Department of Veterans Affairs (VA) staff physician summary letter. This letter must include a brief summary of the patient's primary diagnosis; date of diagnosis; past medical history; past surgical history (if any); any treatment and responses to treatment; co-morbid conditions; review of systems; and current clinical condition at the time of referral. Additional information is required for bone marrow referrals (see Att. B).
2. All sections of the Referral Form must be completed and copies of all required reports and lab data must be provided in the referral packet.
3. All referrals require a thorough social evaluation by a clinical social worker, and psychological evaluation by a psychologist or psychiatrist. When indicated, e.g., conditions such as PTSD, depression, substance abuse, etc., a psychiatric examination, including psychological testing as necessary, is required. Referrals should include evidence, if at all possible, of a firm commitment from a relative and/or a friend for support before, during and after the transplant procedure. The support person is expected to go to the VATC with the patient for evaluation and the transplant episode, provide post-transplant support, accompany the patient to follow-up appointments, assist with medications, ensure compliance, and offer general assistance. The psychological and social evaluations are a critical part of the evaluation process and must address the following issues:
 - a. Family and social history;
 - b. Military history;
 - c. Psychiatric history and response to treatment, if any;
 - d. Patient and family response to treatment plan and their expectations of the treatment results;
 - e. History of tobacco, alcohol, and/or substance abuse with date and documentation of abstinence; any immediate family within the household with a history of, or currently using tobacco, alcohol, and/or illegal drugs; and current treatment plan(s) or rehabilitation program.
 - f. Legal issues;
 - g. Medical compliance with appointments and medications;
 - h. Cognitive impairment that limits comprehension of medical regimen or informed consent;
 - i. Stability of residence and/or support system; and

VHA DIRECTIVE 2001-027

April 27, 2001

- j. Identification of support person and back-up support person if necessary.
4. Active alcohol and/or substance abuse is an absolute contraindication to transplantation through the VA system. If the patient is actively using alcohol and/or illegal drugs, the patient must successfully complete a formal rehabilitation treatment program with documented abstinence (random screens) for a minimum of 6 months. At least 3 months of documented abstinence and successful completion of a rehabilitation program should be included in the referral packet. If the patient has a past history of alcohol and/or substance abuse, current screens must be included in the referral packet and thoroughly addressed in the psychiatric evaluation.
5. Patients should be encouraged to quit use of tobacco products and be referred to a formal smoking cessation program. At least 3 months of documented evidence of successful participation in the program should be included in the referral packet. If the patient has a past history of tobacco use, current screens must be included in the referral packet.
6. Obese patients should be enrolled in a formal weight loss program with documented results.
7. Random screens include the following: nicotine or cotinine for tobacco use; serum alcohol levels for alcohol use; and urine toxicology screens for illegal drugs. The following drugs should be included in the toxicology screen: Amphetamines, Barbiturates, Benzoids, Cannabinoids, Cocaine, Methadone, Opiates, and Propoxyphene.

ATTACHMENT B

**SPECIFIC INFORMATION REQUIRED FOR ALL SOLID ORGAN
AND BONE MARROW TRANSPLANT REFERRALS**

1. Bone Marrow Transplants (BMT)

a. All tissue typing costs are the responsibility of the Department of Veterans Affairs (VA) medical center. For an allogeneic transplant, a Human Leucocyte Antigen (HLA) identical or very similar relative is the preferred donor, and HLA matching should be initiated early in the course of the disease. Expenses for the HLA matching are paid by the VA medical center or Department of Defense (DOD) facility initiating the donor search, and may be performed at any accredited laboratory.

b. If no relative is available or there are no relative matches, then a matched unrelated donor (MUD) search may be sought. Searches for MUDs should be initiated as soon as possible because the average search takes approximately 4 months. The search can be conducted through any VA medical center whose affiliate is a member of the National Marrow Donor Program. Performing the search locally does not mean that the transplant will follow at a local transplant center.

c. The physician referral letter must contain information about the diagnosis (date, disease state and/or stage, pathology or how it was confirmed); initial treatment and response to treatment; date of relapse (if it occurred); pathology and extent; salvage therapy and response; co-morbid conditions; organ function, i.e., PFT/DLCO, MUGA/EF, LFT, renal; what type of transplant is being requested and which center, if there is a preference.

d. Whenever possible, follow-up care should be provided by a VA medical center that is a comprehensive, tertiary cancer center, or one that has access to BMT expertise at its affiliated medical school.

e. Transplants that will not be funded by the Transplant Office are: Phase I and most Phase II trials; care under Phase III trials will usually be funded. Centralized transplant funds are not intended to support clinical research. For BMT transplants, it is necessary that there is adequate and reliable evidence that the procedure is effective and the risks acceptable in the particular disorder considered for transplant.

2. Heart, Lung, and Heart - Lung Transplants

a. In general, candidates for heart transplantation in the VA system should be less than 65 years old; referrals for single lung transplantation should be less than 60 years old; and, double lung transplant should be less than 55. Referrals for heart - lung transplantation in the VA system should be less than 50 years old. Referrals exceeding these age criteria will be considered on a case-by-case basis.

VHA DIRECTIVE 2001-027

April 27, 2001

- b. Active tobacco use is an absolute contraindication for heart and lung transplantation through the VA system.
- c. Weight should not exceed 140 percent of ideal body weight. Obese patients should be enrolled in a formal weight loss program with documented results.

3. Liver Transplants

- a. Patients referred for consideration of liver transplantation must meet minimal transplant listing criteria as established by the United Network for Organ Sharing (UNOS). Under current national guidelines, patients with a Child-Turcotte-Pugh (CTP) score of less than seven cannot be listed on the national waiting list.
- b. In general, candidates for liver transplantation in the VA system should be no older than 65 years old. Referrals exceeding this age criterion will be considered on a case-by-case basis and co-morbid conditions, e.g., coronary artery disease, etc., must be ruled out prior to submission of the referral packet.
- c. Patients who are Hepatitis B surface antigen positive will be evaluated on a case-by-case basis before consideration as a transplant candidate.
- d. Patients diagnosed with hepatocellular carcinoma will be considered for transplantation. However, size and number of lesions must be determined and documented in the referral packet. A patient may be considered for transplantation if there is a single lesion no greater than 5 centimeters (cm.); or no more than two or three lesions, the largest no greater than 3 cm. in size; and, no evidence of disease outside the liver.
- e. Retransplantation of patients with allograft loss due to recurrent Hepatitis C will be considered on a case-by-case basis.

4. Kidney and Kidney-Pancreas Transplants

- a. Veterans electing to use VA benefits must utilize a VA Transplant Center (VATC). VA medical centers should not fee-base veterans, but refer them through the national VA transplant referral system. Being listed at a VATC does not preclude the veteran from also being listed at a Medicare-approved transplant site, but VA will not cover any of the transplant costs if the patient opts to use Medicare benefits.
- b. All HLA typing and cytotoxic screens will be performed at the VATC once the patient has been determined to be a viable candidate for transplantation. Potential donors will also be tested by the VATC once the donor is identified.
- c. Hepatitis C positive patients require a thorough gastroenterology evaluation and full liver function tests. A copy of the biopsy should be included in the packet if available.

PATIENT'S NAME	SOCIAL SECURITY NUMBER
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All transplant referrals must include the following **GENERAL** and **ORGAN SPECIFIC** information. **NOTE: Non-invasive test results/clinical lab tests and psych and social evaluations must be no older than 3 months; invasive test results should be no older than 9 months. Referrals will not be processed without documented evidence of required tests, procedures, and evaluations as listed below.**

PART I (Continued) - GENERAL INFORMATION: Required for all types of transplants referrals.

<input type="checkbox"/> VA staff physician summary letter	<input type="checkbox"/> Discharge summary of last hospitalization	<input type="checkbox"/> Interim summary (if current inpatient)
Evaluations: <input type="checkbox"/> Social	<input type="checkbox"/> Psych	<input type="checkbox"/> Dental
<input type="checkbox"/> List of current medications		
Blood Type: <input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> O
<input type="checkbox"/> AB	<input type="checkbox"/> RH pos/neg	
Serologies: <input type="checkbox"/> HBsAg pos/neg	<input type="checkbox"/> HBsAb pos/neg	<input type="checkbox"/> HCV pos/neg
<input type="checkbox"/> HIV pos/neg	<input type="checkbox"/> CMV IgG pos/neg	<input type="checkbox"/> RPR/VDRL pos/neg
Procedures <input type="checkbox"/> CXR	<input type="checkbox"/> EKG	<input type="checkbox"/> PFT/DLCO
<input type="checkbox"/> Echocardiogram	<input type="checkbox"/> Thallium (if history of hypertension, angina, or cardiac disorder)	
<input type="checkbox"/> PPD	<input type="checkbox"/> Pathology Report (for any surgical procedure)	
Labs: <input type="checkbox"/> CBC	<input type="checkbox"/> UA	<input type="checkbox"/> Chemical Profile
<input type="checkbox"/> Coags	<input type="checkbox"/> TSH	<input type="checkbox"/> T4 (if TSH is abnormal)
<input type="checkbox"/> 24-Hour Creatinine Clearance	<input type="checkbox"/> Urine Toxicology Screen pos/neg	<input type="checkbox"/> Blood ETOH Screen (if history) pos/neg

ORGAN SPECIFIC INFORMATION

BONE MARROW: <input type="checkbox"/> Results of diagnostic bone marrow aspirate and biopsy	<input type="checkbox"/> Results of HLA typing (if allogenic requested)
<input type="checkbox"/> Results of post-chemotherapy sensitivity	<input type="checkbox"/> Results of CT/MRI or Bone Scan
<input type="checkbox"/> Results of MUGA/EF (if post-chemotherapy)	

HEART: <input type="checkbox"/> Results of right and left cardiac catheterization	<input type="checkbox"/> Results of MVO₂
<input type="checkbox"/> Results of trial of vasodilators (if pulmonary pressures are elevated)	
<input type="checkbox"/> Results of MUGA/EF (left and right)	NYHA Class: _____

LUNG: <input type="checkbox"/> Results of right cardiac catheterization (if diagnosis of primary pulmonary hypertension or cor pulmonale)	<input type="checkbox"/> Results of lung biopsy (if available)
<input type="checkbox"/> Results of left cardiac catheterization (if age >50 or CAD)	<input type="checkbox"/> Results of chest CT (with contrast)
<input type="checkbox"/> Results of nuclear gated with left and right ejection fractions	<input type="checkbox"/> Results of alpha one anti-trypsin level
<input type="checkbox"/> Results of polysomnography study (if evidence of sleep apnea)	<input type="checkbox"/> Results of arterial blood gases

LIVER: <input type="checkbox"/> Results of HBcAb pos/neg	<input type="checkbox"/> Results of HAV pos/neg	<input type="checkbox"/> Results of AFP levels
<input type="checkbox"/> Results of HBeAg, HBeAb, and DNA (if HBsAg is positive)	<input type="checkbox"/> Results of liver biopsy (if available)	
<input type="checkbox"/> Results of doppler ultrasound (to measure vessel patency)	<input type="checkbox"/> Results of abdominal CT or MRI	
<input type="checkbox"/> Results of colonoscopy or flexible sigmoidoscopy (if age >50)		

KIDNEY: <input type="checkbox"/> Results of GI consult and liver function tests (if HCV positive)	<input type="checkbox"/> Results of liver biopsy (if HCV PCR positive)
<input type="checkbox"/> Results of colonoscopy or flexible sigmoidoscopy (if age >50)	<input type="checkbox"/> PSA (if age >50)

NOTE: After review of referral packet as outlined above, additional information/test results may be requested by Review Board members.

VA STAFF PHYSICIAN (<i>Print Name and Sign</i>)	TELEPHONE NUMBER	FAX NUMBER	E-MAIL ADDRESS
VA CONTACT PERSON (<i>For Questions/Problems</i>)	TELEPHONE NUMBER	FAX NUMBER	E-MAIL ADDRESS
VA CHIEF OF STAFF (<i>Print Name and Sign</i>)	TELEPHONE NUMBER	FAX NUMBER	E-MAIL ADDRESS

PART II - To be completed by Manager, VA Transplant Program, Washington, D.C.

FINAL DECISION: APPROVE TRANSPLANT CENTER ASSIGNED TO: _____ DEFER DISAPPROVE CANCEL

Comments: _____

VA TRANSPLANT PROGRAM OFFICIAL (<i>Print Name and Sign</i>)	DATE
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