Patient Referral Form for Stem Cell Transplantation/CAR-T therapy to Lymphoid Team

Document Number		**Revision Number**		**Effective Date**	
Owner:		**Approved by:**			

Patient Details	
Patient Name:	**Date of Birth:**
Address:	**Contact Telephone Number:**
First Language:	**Interpreter Required:** **Yes** ☐ **No** ☐
Gender: **Male:** ☐	**Female:** ☐

General Practitioner Details
Name:
Address:

Referral Date:	**Referring Centre:**	**Referring Consultant:**
	Referral Centre MRN:	
Reason for Referral:		
Diagnosis:		**Date of Diagnosis:**

Referral for the Attention of: (Please tick box)	
CAR-T Centre	
SJH ☐	**UHG** ☐
Clinician	

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Patient's Clinical Background	
Disease History (Presentation/ Stage/ IPI/ B symptoms)	
Past Medical History	
Current relevant Comorbidities	
Therapy associated Toxicity	
Active Infections/ known Bacterial Resistance	
Smoking History	
Allergies (antibiotic allergies particularly relevant)	
Transfusion Issues	
Additional relevant Patient Information	

Please Provide an Overview of Previous Chemotherapy Regimens received by the Patient			
Name of chemotherapy regimen:	**Start date of treatment:**	**End date of treatment:**	**Response to treatment:**

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Please complete the relevant sections and attach copies of reports with the completed referral form				
Diagnostic Samples	**Site:**	**Date:**	**Hospital where biopsy stored:**	**Result:**
Pathology				
Bone Marrow Aspirate				
Bone Marrow Trephine				

Relapsed/ refractory *Samples*	**Site:**	**Date:**	**Hospital where biopsy stored:**	**Result:**
Pathology				
Bone Marrow Aspirate				
Bone Marrow Trephine				

Note:

Please send BMA slides, report and immunophenotype to [Hospital name, relevant department and address]

Please send pathology slides (and block) including trephine to [Hospital name, relevant department and address]

Imaging	**Date(s):**	**Hospital where radiology performed:**	**Result:**
PET			
CT			
MRI			
Other			

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If hospital is not on NIMIS the referring centre is requested to send CD of images and reports to [insert the relevant NCCP Designated CAR-T Centre FAO CAR-T Consultant.]

Flow Cytometry	Centre where test completed:	Date:	Please attach copy of report
Molecular studies:	**Centre where test completed and what done:**	**Date:**	**Please attach copy of report**

Radiation centre and Radiation Consultant	Site and dose:	Start Date of Treatment:	End Date of Treatment:	Response:

For allogeneic only (St. James's only):

If the Patient is for consideration of Allogeneic SCT have the following tests been completed?

HLA Typing of Patient **Yes** ☐ **No** ☐

HLA Typing of siblings **Yes** ☐ **No** ☐

***Please attach HLA reports if available**

Please save and send the completed referral form by email to [insert the relevant NCCP Designated CAR-T Centre and email contact details here]

Thank you for completing this form

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