St James's Hospital HOPe Directorate Stem Cell Transplant Unit

Patient Referral Form for Stem Cell Transplantation to Myeloid and Bone Marrow Failure Team

Document Number	MF-SCT-0010	**Revision Number**	3	**Effective Date**	20/01/2022
Owner:	Quality Manager			**Approved by:**	Dr Eibhlin Conneally

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:**
Reason for Referral:		
Diagnosis:		**Date of Diagnosis:**

Referral for the Attention of: (Please tick box)		
Dr Eibhlin Conneally ☐	**Dr Catherine Flynn** ☐	**Dr Orfali** ☐
No Preference ☐		

Diagnostic Presentation	
Clinical Presentation	

Blood Count:	**Hb:**	**WCC:**	**Plts:**
Diagnosis:			
Relapse: (if relevant)			

Please Complete the Sections below Relevant to the Patient, and Attach Copies of Reports with the Completed Referral Form

Diagnostic Tissues:	**Date:**	**Hospital where biopsy sample analysed:**	**Result:**
Bone Marrow Aspirate			
Bone Marrow Trephine			
Other Tissue			

Relapse Tissues: (if relevant)	**Date:**	**Hospital where biopsy sample analysed:**	**Result:**
Bone Marrow Aspirate:			
Bone Marrow Trephine:			
Other Tissue:			

Cytogenetics:	**Centre where test completed:**	**Date:**	**Result:**
Molecular Testing:	**Centre where test completed**	**Date:**	**Result:**

Treatment to Date:	**Regimen:**	**Start Date of Treatment:**	**End Date of Treatment:**	**Response to Treatment:**

Treated-related Complications	
History of infections including resistant organisms:	
CMV Status: (if known)	
Other: e.g. Gastrointestinal, Cardiac, Respiratory, Neurological	

Past Medical History

Current Medications

Allergies
Transfusion Issues (e.g. Allo- immunisation/ reactions etc)

Family History of Blood Disorders

Other Relevant Information

HLA Typing if Completed				
HLA Typing of Patient	**Yes**	☐	**No**	☐
HLA Typing of siblings	**Yes**	☐	**No**	☐

Please supply HLA reports if available at time of referral. If HLA reports are not available at the time of referral please forward ASAP.

For each sibling tested please supply:

- **Name**
- **Date of birth**
- **Date the test was carried out.**

Please also confirm if the sibling tested has been informed of the test result.

Please save and send the completed referral form, with accompanying reports and optional referral letter to the email address below;

sctransplant@healthmail.ie

Thank you for completing this form, the information required is for efficient triage and appropriate assessment.