**St. James's Hospital HOPe Directorate Stem Cell Transplant Unit**

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

| **Document Number** | MF-SCT-0009 | **Revision Number** | 5 | **Effective Date** | 3rd April 2023 |
|---|---|---|---|---|---|
| **Owner:** | Quality Manager | | **Approved by:** | Professor Bacon | |

| **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:**<br>**Referral Centre MRN:** | **Referring Consultant:** |
|---|---|---|
| **Reason for Referral:** | | |
| **Diagnosis:** | | **Date of Diagnosis:** |

| **Referral for the Attention of:** (Please tick box) | | |
|---|---|---|
| **Professor Elisabeth Vandenberghe** ☐ | **Professor Larry Bacon** ☐ | **Dr Robert Henderson** ☐ |
| **No Preference** ☐ | | |

| ***Patient's Clinical Background*** | |
|---|---|
| **Disease History (Presentation/ Stage/ IPI/ B symptoms)** | |
| **Past Medical History** | |
| **Current relevant Co-morbidities** | |
| **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** | | | | |

*Please send*
*BMA slides, report and immunophenotype to* ***Haematology Registrar, Central Pathology Laboratory, St James's Hospital, Dublin, 8***
*Pathology slides (and block) including trephine to* ***Dr Richard Flavin, Histopathology, Central Pathology Laboratory, St James's Hospital, Dublin,***

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

*If hospital is not on NIMIS the referring centre is requested to send CD of images and reports to the.*

| **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:** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

***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 the address below; sctransplant@healthmail.ie**

***Thank you for completing this form***