



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	2	Effective Date	13 th February 2020
Owner:	Quality Manager		Approved by:	Prof E. Vandenberghe	

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)		
Professor Elisabeth Vandenberghe	Dr Larry Bacon	No Preference

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

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

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. MDT Lymphoma Coordinators, Cancer Clinical Trials Offices, HOPE Directorate, St James's Hospital, Dublin 8

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