



## St. James's Hospital HOPE Directorate Stem Cell Transplant Unit

## Patient Referral Form for Stem Cell Transplantation/CAR-T Therapy to Myeloma Team

<b>Document Number</b>	MF-SCT-0011	<b>Revision Number</b>	3	<b>Effective Date</b>	May 2026
<b>Owner:</b>	Quality Manager		<b>Approved by:</b>	Dr Patrick Hayden	

Patient Details	
<b>Patient Name:</b>	<b>Date of Birth:</b>
<b>Address:</b>	<b>Contact Telephone Number:</b>
<b>First Language:</b>	<b>Interpreter Required:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Gender:</b>	Male <input type="checkbox"/> Female <input type="checkbox"/>

General Practitioner Details
<b>Name:</b>
<b>Address:</b>

<b>Referral Date:</b>	<b>Referring Centre:</b>	<b>Referring Consultant:</b>
<b>Reason for Referral:</b>		
<b>Diagnosis:</b>	<b>Date of Diagnosis:</b>	

Referral for the Attention of: (Please tick box)		
<b>Professor Paul Browne</b>	<b>Dr Patrick Hayden</b>	<b>No Preference</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Diagnostic Presentation</b>	
<b>Clinical Presentation</b>	

<b>Blood Count:</b>	<b>Hb:</b>	<b>WCC:</b>	<b>Plts:</b>
<b>Diagnosis</b>			

<b>Paraprotein/Urinary Protein:</b>	<b>Albumin:</b>	<b>B2M:</b>	<b>Creatinine:</b>

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

<b>Diagnostic Tissues:</b>	<b>Date:</b>	<b>Hospital where biopsy stored:</b>	<b>Result:</b>
<b>Bone Marrow Aspirate</b>			
<b>Bone Marrow Trepine</b>			
<b>Other Tissue</b>			

<b>FISH Cytogenetics</b>	<b>Centre where test completed:</b>	<b>Date:</b>	<b>Result:</b>

<b>Imaging at Diagnosis</b>	<b>Date:</b>	<b>Hospital where radiology performed:</b>	<b>Result:</b>
<b>PET</b>			
<b>CT</b>			
<b>MRI</b>			
<b>Other</b>			

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

Centre where Radiation provided and Name of Radiation Consultant	Site and dose	Start Date of Treatment	End Date of Treatment	Response

Treated-related complications

<i>Medical History</i>	
Medical History	
History of infections including resistant organisms	

<i>Medications</i>

<i>Allergies</i>

<i>Social History</i>

<i>Family History</i>

Please save and send the completed referral form and accompanying reports by email to the address below;  
[sctransplant@healthmail.ie](mailto:sctransplant@healthmail.ie)

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