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

# Patient Referral Form for Stem Cell Transplantation to Myeloma Team

| **Document Number** | MF-SCT-0011 | **Revision Number** | 2 | **Effective Date** | 4th May 2021 |
|---|---|---|---|---|---|
| **Owner:** | Quality Manager | | | **Approved by:** | Dr Patrick Hayden |

| **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 Paul Browne** ☐ | **Dr Patrick Hayden** ☐ | **No Preference** ☐ |

| ***Diagnostic Presentation*** | |
|---|---|
| **Clinical Presentation** | |

| **Blood Count:** | **Hb:** | **WCC:** | **Plts:** |
|---|---|---|---|
| **Diagnosis** | | | |

| **Paraprotein/Urinary Protein:** | **Albumin:** | **B2M:** | **Creatinine:** |
|---|---|---|---|
| | | | |

| ***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 stored:** | **Result:** |
|---|---|---|---|
| **Bone Marrow Aspirate** | | | |
| **Bone Marrow Trephine** | | | |
| **Other Tissue** | | | |

| **FISH Cytogenetics** | **Centre where test completed:** | **Date:** | **Result:** |
|---|---|---|---|
| | | | |

| **Imaging at Diagnosis** | **Date:** | **Hospital where radiology performed:** | **Result:** |
|---|---|---|---|
| **PET** | | | |
| **CT** | | | |
| **MRI** | | | |
| **Other** | | | |

| **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** |
|---|
| |

| ***Medical History*** | |
|---|---|
| **Medical History** | |
| **History of infections including resistant organisms** | |

| ***Medications*** |
|---|
| |

| ***Allergies*** |
|---|
| |

| ***Social History*** |
| --- |
| |

| ***Family History*** |
| --- |
| |

**Please save and send the completed referral form and accompanying reports by email to the address below;**
**sctransplant@healthmail.ie**

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