



**St. James's Hospital HOPE Directorate Stem Cell Transplant Unit**  
**Patient Referral Form for Stem Cell Transplantation to Myeloid and Bone Marrow Failure Team**

<b>Document Number</b>	MF-SCT-0011	<b>Revision Number</b>	1	<b>Effective Date</b>	21 <sup>st</sup> October 2020
<b>Owner:</b>	Peig Carroll			<b>Approved by:</b>	Dr Eibhlin Conneally

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)		
Dr Eibhlin Conneally <input type="checkbox"/>	Dr Catherine Flynn <input type="checkbox"/>	No Preference <input type="checkbox"/>

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

<b>Blood Count:</b>	<b>Hb:</b>	<b>WCC:</b>	<b>Plts:</b>
<b>Diagnosis:</b>			
<b>Relapse: (if relevant)</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 sample analysed:</b>	<b>Result:</b>
<b>Bone Marrow Aspirate</b>			
<b>Bone Marrow Trepine</b>			
<b>Other Tissue</b>			

<b>Relapse Tissues: (if relevant)</b>	<b>Date:</b>	<b>Hospital where biopsy sample analysed:</b>	<b>Result:</b>
<b>Bone Marrow Aspirate:</b>			
<b>Bone Marrow Trepine:</b>			
<b>Other Tissue:</b>			

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

<b>Molecular Testing:</b>	<b>Centre where test completed</b>	<b>Date:</b>	<b>Result:</b>

<b>Treatment to Date:</b>	<b>Regimen:</b>	<b>Start Date of Treatment:</b>	<b>End Date of Treatment:</b>	<b>Response to Treatment:</b>

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

<b><i>Past Medical History</i></b>

**Current Medications**

<b>Current Medications</b>

**Allergies**

<b>Allergies</b>

**Family History of Blood Disorders**

<b>Family History of Blood Disorders</b>

**Other Relevant Information**

<b>Other Relevant Information</b>

**HLA Typing if Completed**

<b>HLA Typing of Patient</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>HLA Typing of siblings</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**Please provide the following information:**

**The name and date of birth of each sibling tested and the 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](mailto:sctransplant@healthmail.ie)

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