



St. James's Hospital HOPE Directorate  
**Patient Referral Form for Lymphoma MDT**

<b>Document Number</b>	MF-SCT-0012	<b>Revision Number</b>	2	<b>Effective Date</b>	13 <sup>th</sup> February 2020
<b>Owner:</b>	Quality Manager			<b>Approved by:</b>	Prof E. Vandenberghe

<b>Patient Details</b>	
<b>Patient Name:</b> <b>Address:</b>	<b>Date of Birth:</b>
<b>General Practitioner Details</b>	
<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>	

<b>Referral for the Attention of:</b>		
<b>Dr Larry Bacon</b> <input type="checkbox"/>	<b>Dr Cliona Grant</b> <input type="checkbox"/>	<b>Professor Elisabeth Vandenberghe</b> <input type="checkbox"/>
<b>Dr Patricia Daly</b> <input type="checkbox"/>	<b>Dr Charles Gilham</b> <input type="checkbox"/>	<b>No Preference</b> <input type="checkbox"/>

<b>Please state Date you wish Patient to be Presented:</b> (referring doctor should be available to present patient details)			
<b>Day:</b>		<b>Month:</b>	
		<b>Year:</b>	
<b>Please Attach Copies of Reports to the Completed Referral Form</b> (BMA & Trephine plus pathology samples may be requested for individual patients)			
<b>Diagnostic Tissue:</b>	<b>Date:</b>	<b>Hospital where biopsy stored:</b>	<b>Result:</b>
Bone Marrow Aspirate			
Bone Marrow Trephine			
Lymph Node Biopsies			
Cerebrospinal Fluid			
Other			

<b>Tissue Samples at Relapse/ Refractory</b>	<b>Date:</b>	<b>Hospital where biopsy stored:</b>	<b>Result:</b>
Bone Marrow Aspirate			
Bone Marrow Trephine			
Lymph Node Biopsies			
Cerebrospinal fluid			
Other			

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

<b>*Imaging at Relapse/ Refractory</b>	<b>Date(s):</b>	<b>Hospital where radiology performed:</b>	<b>Result(s):</b>
PET(s)			
CT(s)			
MRI (s)			
Other			

\* If the hospital is not on NIMIS please send CD of images and a copy of this referral form to the [address below](#);  
**MDT Coordinators, Cancer Clinical Trials Offices, HOPE Directorate, St James's Hospital, Dublin 8**

<b>Centre where Radiation was provided and the name of Radiation Consultant:</b>	<b>Site and dose of radiation:</b>	<b>Start Date of Treatment:</b>	<b>End Date of Treatment:</b>	<b>Response:</b>

Please save and send the completed referral form by email to the address below;  
[lymphomaMDT@stjames.ie](mailto:lymphomaMDT@stjames.ie)