Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Hôpital Hotel Dieu Hospital

KGH Hôpital Général de Kingston General Hospital

STEM CELL TRANSPLANT AND CELLULAR THERAPY PROGRAM

CAR-T Therapy Referral

Phone: (613) 549-6666 **Ext**. 6627 **Confidential Fax**: (613) 548-2499
Email: MHDUCellularTherapy@kingstonhsc.ca

Patient Name:
Date of Birth:
OHIP #:
Address:
Phone:
Email:

REFERRAL INFORMATION (*Please note: Incomplete referrals will not be processed until all diagnostics / reports received)*

Referral Submission Date (yyyy/mm/dd): _____ Physician Name: _____

Primary Nurse: _____ Phone: (____)_____ Extension: _____

Email: _____ Institution/Department: _____

PATIENT INFORMATION

Diagnosis: ☐ B-ALL ☐ High grade B Cell Lymphoma ☐ Primary Mediastinal B Cell Lymphoma ☐ DLBCL ☐ Mantle Cell Lymphoma
☐ FL specify grade: _____

Other Diagnosis: _____

Diagnosis Date (YYYY/MM/DD): _____

Current Disease Status: _____

☐ Treatment to date:

	Date Initiated	Date Completed	Name of Therapy/Regimen	No. of Cycles (if app)	Best Response to Therapy
1					
2					
3					
4					
5					

History of non-cellular anti-CD19 therapy? ☐ Yes, specify therapy _____ and date (YYYY/MM/DD)_____ or ☐ No

History of CAR T-cell therapy? ☐ Yes or ☐ No

Central Venous Access Device: ☐ Yes, type: _____ insertion date (YYYY/MM/DD): _____ no. lumens _____ or ☐ No

☐ Patient height _____ cm and weight _____ kg.

CAR T CONSULT REFERRAL – ITEMS REQUIRED FOR APPLICATION

Instructions: *complete the checklist to verify appropriate documents are included in the referral.*

☐ Consult note and recent clinic notes
☐ Pathology reports: at ☐ Diagnosis ☐ Remission (or ☐ N/A) and ☐ Relapse (or ☐ N/A)
☐ Karnofsky Performance Score (KPS) ≥ 70% (specify): _____ %
☐ Relevant cytogenetic reports/molecular information
☐ Relevant bone marrow reports
☐ CT or PET imaging documenting relapsed refractory disease or bone marrow pathology
☐ Recent PFT or ☐ Not completed
☐ Recent ECG and 1 of echocardiogram/MUGA or ☐ Pending
☐ Recent MRI or CT head if suspected CNS involvement or ☐ Not completed
☐ Recent blood work: CBC, Differential, Electrolytes, Creatinine, Glucose, Urea, Calcium, Magnesium, Phosphate, LVT's, Albumin, Bilirubin, AST, ALT, ALP, Total protein, recent transmissible disease testing.
For patients without Ontario Health Insurance Plan (OHIP) coverage, has provincial ministry letter been provided? ☐ Yes or ☐ No (pending)

Form Completed By (referring physician):			
Print Name	Signature / Designation	Date (yyyy/mm/dd)	Time (hhmm)

KHSC CELL TRANSPLANT AND CELLULAR THERAPY PROGRAM OFFICE USE ONLY:		
REFERRAL DECISION (Check most appropriate)		
Yes ☐ Please see appointment details below	**Tentative** ☐ Please send confirmation of provincial funding. Once received, your patient will be contacted directly with an appointment	**Declined** ☐ KHSC is at full capacity and cannot accept new CAR-T referrals at this time. Please redirect referral to another CAR T-cell therapy centre. ☐ Patient does not meet eligibility criteria and is not a candidate for CAR-T. The patient will be seen in a disease-site specific clinic for additional evaluation. ☐ Patient does not meet eligibility criteria and is not a candidate for CAR-T. No appointment at KHSC has been made
Date Received (YYYY/MM/DD)**:**	Appointment Date (YYYY/MM/DD)**:**	Appointment Time (HHMM)**:**

Abbreviations		
ALL – Acute lymphoblastic leukemia	ECG – Electrocardiogram	AST – Aspartate Aminotransferase
DLBCL – Diffuse Large B-Cell Lymphoma	MUGA – Multigated Acquisition Scan	ALT – Alanine Aminotransferase
FL – Follicular Lymphoma	MRI – Magnetic Resonance Imaging	ALP – Alkaline Phosphatase
CT – Computerized Tomography	CNS – Central Nervous System	ALP – Alkaline Phosphatase
PET – Positron Emission Tomography	CBC – Complete Blood Count	
PFT – Pulmonary Function Test	LFT –Liver Function Test	