

STEM CELL TRANSPLANT PROGRAM Autologous Stem Cell Transplant Referral

Phone: (613) 549-6666 Ext. 6627 Fax: (613) 548-2499

Patient Name: _____

Date of Birth: _____

OHIP #: _____

Address: _____

Phone: _____

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: _____

TRANSPLANT CONSULT REFERRAL – GENERAL CHECKLIST

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

- | | |
|---|--|
| <input type="checkbox"/> Referral Note / Disease History and Response / Clinic Notes | <input type="checkbox"/> Other consult service(s) notes involved in care |
| <input type="checkbox"/> Chemotherapy treatment history (include dates / doses) | <input type="checkbox"/> Radiation therapy history (include dates / doses) |
| <input type="checkbox"/> Relevant pathology reports | |
| <input type="checkbox"/> Recent blood work: CBC, Differential, Electrolytes, Creatinine, Urea, Calcium, Magnesium, Albumin, Bilirubin, AST, ALT, ALP, Total protein | |

ADDITIONAL REQUIREMENTS BY DISEASE SITE – LYMPHOMA / GERM CELL TUMOUR

- CT Scans (*as applicable*): Initial Response to Treatment Disease Progression / Transformation Response after Salvage Therapy
- Functional Imaging, if applicable
- Bone Marrow Aspirate and Biopsy Results
- Disease Re-Staging Results

ADDITIONAL REQUIREMENTS BY DISEASE SITE – MYELOMA

- Skeletal survey and other applicable imaging
- Bone Marrow Aspirate and Biopsy Results
- FISH cytogenetics results
- Myeloma Response Bloodwork: Serum Protein Electrophoresis (SPEP), Immunoglobulins (e.g. IgG, IgA, IgM) and/or, Free Light Chain Protein Studies

Please arrange the following tests and FAX when available:

- Recent ECHO or MUGA

Form Completed By:

_____	_____	_____	_____
Print Name	Signature / Designation	Date (yyyy/mm/dd)	Time (hhmm)

MALIGNANT HEMATOLOGY DAY UNIT OFFICE USE ONLY:

Date Received (yyyy/mm/dd):	Appointment Date (yyyy/mm/dd):	Appointment Time (hhmm):
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Abbreviations

ALT - Alanine Aminotransferase	CT - Computerized Tomography	PFT - Pulmonary Function Test
AST - Aspartate Aminotransferase	ECHO - Echocardiogram	SPEP - Serum Protein Electrophoresis
ALP - Alkaline Phosphatase	FISH - Fluorescence in situ Hybridization	
CBC - Complete Blood Count	MUGA - Multigated Acquisition Scan	

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