



**LEUKEMIA/BONE MARROW TRANSPLANT PROGRAM
OF BRITISH COLUMBIA**

10th floor, 2775 Laurel Street, Vancouver V5Z 1M9
P: 604 875 4863 F: 604 875 4763

CAR-T REFERRAL FORM

PLEASE NOTE: An appointment will not be booked until we have received the following information.

PATIENT DEMOGRAPHIC INFORMATION

First Name:	Address:
Last Name:	
DOB:	Home Phone:
PHN:	Cell Phone:
Cancer Agency #:	Work Phone:
Family Doctor:	Email:
Diagnosis:	
Is your patient aware of this referral? Yes No	

At this time, we are only assessing patients for CAR-T clinical trials and do not have access to commercial products. Please ensure the patient is aware of this, and provide a rationale for pursuing a trial in the space below:

REQUIRED CLINICAL INFORMATION

if a result is pending, please indicate this below and forward to our office once the results are available

✓	Checklist	Pending?	
	Consult and Recent Progress Notes (including all therapy dates)	Yes	No
	ECOG Performance Status	Yes	No
	Bone Marrow Biopsy (if available)	Yes	No
	Pathology Reports (include staining for CD19, if available)	Yes	No
	Cytogenetics and Molecular studies (if available)	Yes	No
	Applicable imaging reports (PET/CT scans, CT scans, MRI)	Yes	No
	Most recent echocardiogram, ECG, MUGA results (if available)	Yes	No
	Pulmonary Function Testing (if available)	Yes	No
	HepB, HepC, and HIV serology	Yes	No
	CBC, lytes, Cr, Ca, liver profile, LDH, CRP, Ferritin (within last 30 days)	Yes	No
	Other (please specify) :	Yes	No

Referring Physician Name:
Referring Physician Phone:
Date of Referral:

MSP #:
Fax:

Please fax the completed referral package to Hematology Reception 604 875 4763