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: **MSP#**	**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: MSP #:
Referring Physician Phone: Fax:
Date of Referral:

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