Hamilton Health Sciences

JCC - SCBMT Program

Allogeneic Stem Cell Transplant Referral

(Please fax completed referrals to 905-575-6316)

Date: (yyyy/mm/dd) _____

Patient's Last Name First Name

ID Number HIN Version Code

Patient's Birthdate (yyyy/mm/dd) Age Gender ☐ M ☐ F

PATIENT INFORMATION

Last Name:	Date of Birth: (yyyy/mm/dd)	
First Name:	Health Card #	Version Code:
Street Address:	City:	Province:
Phone (home)	(work)	(cell)
Next of Kin:	Relationship	Phone

Are Interpreter Services Required? ☐ No ☐ Yes → Language _____

PHYSICIAN INFORMATION

Referring Physician	Physician's Signature
Phone / Pager	Email
Fax	OHIP Billing Number
Family Physician	Family Physician Phone

DIAGNOSIS

- ☐ Acute Myelocytic Leukemia
- ☐ Acute Lymphoblastic Leukemia
- ☐ Lymphoblastic Lymphoma
- ☐ Chronic Lymphocytic Leukemia
- ☐ Chronic Myelocytic Leukemia
- ☐ Hodgkin Lymphoma
- ☐ Diffuse Large B-Cell Lymphoma
- ☐ Follicular Lymphoma
- ☐ Non-Hodgkin Lymphoma
- ☐ Severe Aplastic Anemia
- ☐ Myelodysplastic/Myeloproliferative Disease
- ☐ Myelofibrosis
- ☐ CMML
- ☐ Other _____

REASON FOR REFERRAL

☐ Allogeneic Stem Cell Transplant ☐ 2nd Opinion ☐ Other

Comments:

Date of Diagnosis (yyyy/mm/dd): _____

Induction/Initial Therapy _____ Start Date (yyyy/mm/dd)): _____

Number of Consolidations given: _____ Start date of last Consolidation (yyyy/mm/dd): _____

Has Relapse or Disease Progression Occurred: ☐ No ☐ Yes → Date (yyyy/mm/dd) _____

Re-induction/Salvage Treatment and Start Date if Applicable (yyyy/mm/dd): _____

Patient's Current Weight: _____ Kg

Has Patient Received a Prior SCT: ☐ No ☐ Yes → Date of Prior SCT (yyyy/mm/dd) _____

Location of Prior SCT: _____ Was Prior SCT Reported to CIBMTR? ☐ No ☐ Yes

Upon receipt of referral form, and registration of patient, scan Referral form Immediately into MOSAIC

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Note: the following information is needed at time of referral	**Sent**	**Pending**	**Date to Expect Results** (yyyy/mm/dd)
Pathology reports including: Bone marrow aspirate and biopsy, tissue biopsy, mass spectrometry.	☐	☐	
Cytogenetics, FISH report and molecular testing.	☐	☐	
Clinic notes: Summary of treatment to date, including when treatment started, delays, changes etc.	☐	☐	
Routine hematology and biochemistry tests at diagnosis including trends if applicable.	☐	☐	
Reports of advanced imaging CT scans, MRI, LDCT and PET/CT if performed.	☐	☐	
Reports of Echocardiograms and PFTs if completed.	☐	☐	
Relevant Additional studies / Other (please specify).	☐	☐	

Regional Oncology Complex Haematology Analytics (ROCHA) F-BMT-0122

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