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 PROGRAM

## Autologous Stem Cell Transplant Referral

**Phone**: (613) 549-6666 **Ext**. 6627 **Confidential 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.*

- ☐ Referral Note / Disease History and Response / Clinic Notes
- ☐ Other consult service(s) notes involved in care
- ☐ Chemotherapy treatment history (include dates / doses)
- ☐ Radiation therapy history (include dates / doses)
- ☐ Relevant pathology reports
- ☐ 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): |
|---|---|---|
| | | |

**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 | |