CAR-T Therapy Referral Form

Blood and Marrow Transplant Program, London Health Sciences Centre

Phone: 519-685-8600 | Confidential Fax: 519-685-8628

Referral Guidelines

1. This form is intended for referrals of patients meeting criteria for CAR-T-cell therapy.
2. Please fill out entirety of form and have all accompanying documents attached.
3. Fax completed form and any accompanying documentation to Verspeeten Family Cancer Centre at **519-685-8628.**

Patient-Specific Information

Patient Name: _____ Home Address: _____

Diagnosis: _____ City & Province: _____

Ontario Health Card #: _____ Primary Phone: _____

Date of Birth (YYYY/MM/DD): _____ Secondary Phone: _____

Language (*if not English*) _____ Email: _____

Referring Centre Information

Referring Centre: _____

Referring Physician: _____

Email: _____

Phone number: _____

Fax (if applicable) _____

Note: This patient will remain under the care of the referring physician until seen by the CAR-T hematologist at Verspeeten Family Cancer Center.

CAR T Specific Patient Information

Please choose the appropriate indication below:

☐ DLBCL → If DBCL, indicate lines of therapy: _____

☐ MCL ☐ FL ☐ ALL ☐ Other (specify): _____

Diagnosis Date (YYYY/MM/DD): _____ Current Disease Status: _____

☐ Most recent clinical note included, including history of previous cancer treatments (i.e. lines of therapy, how patient tolerated previous lines of therapy).

Pathology reports included at:
☐ Diagnosis ☐ Remission ☐ Relapse ☐ N/A

☐ Cytogenetics report/molecular information included.

☐ Karnofsky Performance Score (KPS) (specify %): _____

History of treatment to date, including when treatment started and response:

1. _____

2. _____

3. _____

Central venous access device: ☐ Yes ☐ No

→ *If yes*, type: _____ Date inserted: (YYYY/MM/DD) _____ # lumens: _____

☐ Copy of recent CT or PET scan report documenting relapsed refractory disease OR bone marrow pathology included.

☐ Recent echocardiogram with report included **OR** ☐ Pending

☐ Recent MRI head or CT head if CNS disease suspected **OR** ☐ N/A

☐ Recent results of blood work, including at minimum CBC and differential, electrolytes, creatinine, glucose, urea, calcium, magnesium, phosphate, albumin, LFTs, any IDMs.

Patient height(cm): _____ cm Patient weight (kg): _____ kg

Has CAR-T cell therapy been discussed as a potential option for this patient? ☐ Yes ☐ No

Is there any additional information we need to know?