

UHN BMT-IEC Program
Please fax completed referrals to 416 946 2900

Form 3B.2.5 Multiple Myeloma Autologous Stem Cell Transplant Referral Form Criteria

PATIENT INFORMATION							
Last Name:							
First Name:							
Health Card #:		Version Code:					
Date of Birth (mmm/dd/yyyy):				Place Patient stamp or sticker here if available			
Street Address:							
City: Province:		Postal Code:					
Phone (Home):		Phone (Cell):		Phone (Work):			
Alternate Contact Name:		Relationship:		Phone (Home		/Cell):	
Fluent in English:		Are Inte		terpretation Services required?		Yes □ No	
PHYSICIAN INFORMATION							
Referring Physician Name: OHIP billing #			Direct Referrin	rect Referring Physician phone number:		Referring Physician Fax:	
Training i hysidair Name.			·	3 , 1			
Referring Physician Email: Family Physic		an Name:	Family Physicia	amily Physician Phone:		Family Physician Fax:	
DIAGNOSIS: Multiple Mye	loma Oth	ner (please specify):					
REASON FOR REFERRAL: ASCT Primary Care Clinical Trials 2 nd Opinion Other							
Comments:							
Induction Regimen and Start Date:							
Induction Regimen and Star	t Date:						
		cannot be booked w	rithout the	following	informatio	n available:	
	ppointment		rithout the	following Pending		on available: o Expect Results/Commer	nts
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PLEASE NOTE: THIS PATIENT REMAINS UNDER THE CARE OF THE REFERRING PHYSICIAN UNTIL SEEN AT **PRINCESS MARGARET**