

Form 18.5.3 IEC Referral Checklist

PATIENT INFORMATION			
Last Name:		Place PHI here	
First Name:			
Health Card #:	Version Code:		
Date of Birth (mmm/dd/yyyy):			
Street Address:			
City:	Province:		
Phone (Home):		Phone (Cell):	Phone (Work):
Alternate Contact Name:		Relationship:	Phone (Home/Cell):
Fluent in English: <input type="checkbox"/> Yes <input type="checkbox"/> No Preferred Language:		Are Interpretation Services required? <input type="checkbox"/> Yes <input type="checkbox"/> No	

PHYSICIAN INFORMATION			
Referring Physician Name:	OHIP billing #	Direct Referring Physician phone number:	Referring Physician Fax:
Referring Physician Email:	Family Physician Name:	Family Physician Phone:	Family Physician Fax:

DIAGNOSIS:		
<input type="checkbox"/> ALL	<input type="checkbox"/> High grade B Lymphoma	<input type="checkbox"/> Primary Mediastinal B Cell Lymphoma
<input type="checkbox"/> DLBCL	<input type="checkbox"/> Transformed DLBCL from FL	<input type="checkbox"/> Other:

REASON FOR REFERRAL:		
<input type="checkbox"/> CAR-T	<input type="checkbox"/> 2nd Opinion	<input type="checkbox"/> Other:

Note: An appointment cannot be booked without the following information available:

<u>Pending Information Still Required</u>	Received	Pending	Comments
Pathology reports: Bone marrow aspirate and biopsy, tissue biopsy etc.	<input type="checkbox"/>	<input type="checkbox"/>	
Cytogenetics report, molecular information if applicable	<input type="checkbox"/>	<input type="checkbox"/>	
Clinical notes: Summary of treatment to date, including when treatment started, delays, changes	<input type="checkbox"/>	<input type="checkbox"/>	
Reports of Echocardiogram, ECG, MUGA	<input type="checkbox"/>	<input type="checkbox"/>	
Reports of Pulmonary Function Test if available	<input type="checkbox"/>	<input type="checkbox"/>	
Recent Transmissible Disease Testing if available	<input type="checkbox"/>	<input type="checkbox"/>	
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	

PLEASE NOTE: THIS PATIENT REMAINS UNDER THE CARE OF THE REFERRING PHYSICIAN UNTIL SEEN AT PM CANCER CENTRE

REFERRAL DECISION (Check most appropriate statement)		
YES <input type="checkbox"/> Please see appointment details below	TENTATIVE <input type="checkbox"/> Please send confirmation of provincial funding. Once received, your patient will be contacted directly with an appointment	DECLINED <input type="checkbox"/> Princess Margaret is at full capacity and cannot accept new CAR-T referrals at this time. Please re-direct this referral to _____. <input type="checkbox"/> Princess Margaret is at full capacity and cannot accept new CAR-T referrals at this time. Please connect with Ontario health and consider an out of country referral. <input type="checkbox"/> The patient does not meet eligibility criteria and is not a candidate for CAR-T. The patient will be seen in a disease-site specific clinic for further evaluation. <input type="checkbox"/> The patient does not meet eligibility criteria and is not a candidate for CAR-T. No appointment at Princess Margaret will be made.

APPOINTMENT INFO – Please notify your patient of the following appointment with Dr. _____

DATE (mmm/dd/yyyy):	TIME:
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Location: Princess Margaret Cancer Centre, 610 University Avenue,
2nd Floor, Hematology Clinic: North South West

Please ask patient to confirm appointment: 416-946-_____