

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

PATIENT INFORMATION			
Last Name:		Place Patient stamp or sticker here if available	
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"/> Multiple Myeloma <input type="checkbox"/> Other (please specify):			
REASON FOR REFERRAL: <input type="checkbox"/> ASCT <input type="checkbox"/> Primary Care <input type="checkbox"/> Clinical Trials <input type="checkbox"/> 2 nd Opinion <input type="checkbox"/> Other			
Comments:			
Induction Regimen and Start Date:			

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

CHECKLIST FOR A COMPLETE REFERRAL: (REQUIRED)	Sent	Pending	Date to Expect Results/Comments
Pathology reports: Bone marrow aspirate and biopsy, tissue biopsy, mass spectrometry	<input type="checkbox"/>	<input type="checkbox"/>	
Cytogenetics report, including FISH	<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"/>	
Serum protein electrophoresis(SPEP, M-Spike), immunofixation (IFE) and quantitative immunoglobulin levels (IgG/IgA/IgM), including trends	<input type="checkbox"/>	<input type="checkbox"/>	
24-hour urine total protein, electrophoresis (UPEP), and immunofixation (IFE)	<input type="checkbox"/>	<input type="checkbox"/>	
Serum free light chains assay	<input type="checkbox"/>	<input type="checkbox"/>	
Routine hematology and biochemistry tests (please include LDH at diagnosis/relapse if available)	<input type="checkbox"/>	<input type="checkbox"/>	
Initial Beta 2 Microglobulin level	<input type="checkbox"/>	<input type="checkbox"/>	
Reports of skeletal survey	<input type="checkbox"/>	<input type="checkbox"/>	
Reports of staging CT scans, MRI, functional imaging (PET scans), if performed	<input type="checkbox"/>	<input type="checkbox"/>	
ECHO, PFTs, if completed	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac Biomarkers (troponin/BNP), if performed	<input type="checkbox"/>	<input type="checkbox"/>	
Additional studies if performed (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	

PLEASE NOTE: THIS PATIENT REMAINS UNDER THE CARE OF THE REFERRING PHYSICIAN UNTIL SEEN AT PRINCESS MARGARET