Princess Margaret Cancer Centre

UHN BMT- IEC Program

Please submit completed referrals to PMcelltherapy@uhn.ca

Form 18.5.3 IEC Referral Checklist

PATIENT INFORMATION

Last Name:			Place Patient Health Information Label Here
First Name:			
Health Card Number:		Version Code:	
Date of Birth (mmm/dd/yyyy):			
Street Address:			
City:	Province:	Postal Code:	

Patient's Primary Contact Number:	Patient's Alternate Contact Number:	
Patient's Email Address:		
Alternate Contact Name:	Relationship:	Alternate Contact's Phone Number (Home/Cell):
Fluent in English: ❑ Yes ❑ No Preferred Language:	Are Interpretation Services required? ❑ Yes ❑ No	

PHYSICIAN INFORMATION

Referring Physician Name:	Billing #	Direct Referring Physician phone number:	Referring Physician Fax:
Referring Physician Email:	Family Physician Name:	Family Physician Phone:	Family Physician Fax:

DIAGNOSIS:

☐ ALL ☐ High grade B Lymphoma ☐ Primary Mediastinal B Cell Lymphoma

☐ DLBCL ☐ Transformed DLBCL from FL ☐ Other:

REASON FOR REFERRAL:

☐ CAR T ☐ 2nd Opinion ☐ Other:

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

Pending Information Still Required	**Comments**
Pathology reports: Bone marrow aspirate and biopsy, tissue biopsy etc.	
Cytogenetics report, molecular information if applicable	
Clinical notes: Summary of treatment to date, including when treatment started, delays, changes	
Reports of Echocardiogram, ECG, MUGA	
Reports of Pulmonary Function Test if available	
Recent Transmissible Disease Testing if available	
Blood work (CBC, Creatinine, LFT, LDH)	
Other (specify)	

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