UHN Princess Margaret Cancer Centre

UHN BMT-IEC Program

Form 3A.4.13 Sickle Cell Referral for Allogeneic Transplant

Patient Name: _____

Date of Birth: _____ (mmm/dd/yyyy) **MRN/OHIP:** _____

Please complete checklist below and provide copies of all requested documents.

	Documents requested by Princess Margaret Cancer Center
Potential Donor information	☐ Confirmation of siblings: Number of siblings:_____ HLA typing available ☐ No ☐ Yes, attached
Indications for Allo BMT **(✓ as appropriate)**	☐ Overt stroke or neurologic deficit lasting over 24 hours ☐ Recurrent acute chest syndrome (ACS) (i.e. greater than or equal to 2 episodes of ACS in lifetime) despite supportive care (hydroxyurea, regular transfusion therapy) ☐ Recurrent vaso-occlusive crisis (VOC) (i.e. greater than or equal to 2 episodes of VOC in last 2 years, despite supportive care (hydroxyurea, regular transfusion therapy, pain management). ☐ Regular RBC transfusion therapy (greater than or equal to 8 transfusions per year for greater than or equal to 1 year) to prevent vaso-occlusive complications (i.e. VOC, stroke, or ACS) ☐ Impaired neuropsychological function or silent infarct with abnormal cerebral magnetic resonance imaging and angiography ☐ Avascular necrosis of greater than or equal to 2 joints ☐ Priapism greater than or equal to 2 episodes per year requiring medical attention ☐ Bilateral proliferative retinopathy with visual impairment in at least one eye ☐ Red cell alloimmunization during long-term transfusion therapy ☐ Pulmonary hypertension (clinical features and pulmonary artery pressure greater than 25mm Hg or Tricuspid regurgitant jet velocity greater than or equal to 2.7m/sec on echo) ☐ Sickle nephropathy (moderate or severe proteinuria, glomerular filtration rate 30 to 50% of the predicted normal value, or serum creatinine greater than or equal to1.5 times the upper) ☐ Sickle liver disease (elevated direct bilirubin (greater than0.4 mg/dL or 7umol/L) or ferritin greater than1000 ng/L) ☐ Sickle lung disease Stage I or II ☐ Other: _____
For External Referrals (outside UHN) Most Recent Clinical Note Date of Note:_____ (mmm/dd/yyyy)	☐ Clinical note shall include: ☐ Summary of treatment received ☐ Infectious diseases/ complications ☐ Coexisting co-morbidities

Return form to Search Coordinators by FAX # 416-946-2367 or Email: sctsearch@uhn.ca Phone # 416-946-2268

Referring Physician (print name): _____ **Date:** _____
(mmm/dd/yyyy)

Triage Physician (print name): _____ **Date:** _____
(mmm/dd/yyyy)