Form 4D.1.2 Extracorporeal Photopheresis Referral Form

Patient Name: _____ **Contact Number:** _____

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

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

	Documents requested by Princess Margaret Cancer Center
Referring Center:	Referring Center Name:_____ Referring Center Contact:_____
Indication for Treatment	☐ Acute Graft versus Host Disease ☐ Chronic Graft versus Host Disease ☐ Cutaneous T-Cell Lymphoma/Sezary Syndrome ☐ Other, specify:_____
Initial Consult Note ☐ N/A	☐ Initial consult note
Most Recent Clinical Note Date of Note:_____ (mmm/dd/yyyy)	Clinical note shall include: ☐ Summary of treatment received ☐ Extent/location of disease ☐ Coexisting co-morbidities ☐ Infectious diseases/ complications ☐ GVHD grade
Current Medical List	☐ Attached with referral request
Interpreter Required	☐ Yes, specify language _____ ☐ No
Additional Comments	

Return form to the Apheresis Unit at Toronto General Hospital by FAX # 416-340-3348

Referring Physician: _____ **Signature:**_____ **Date:**_____
Name (mmm/dd/yyyy)

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