UHN Princess Margaret Cancer Centre

UHN BMT-IEC Program

Please fax completed referrals to 416 946 2900

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:	Postal Code:	

Phone (Home):	Phone (Cell):	Phone (Work):
Alternate Contact Name:	Relationship:	Phone (Home/Cell):
Fluent in English: ❑ Yes ❑ No Preferred Language:	Are Interpretation Services required? ❑ Yes ❑ 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: ☐ Multiple Myeloma ☐ Other (please specify):

REASON FOR REFERRAL: ☐ ASCT ☐ Primary Care ☐ Clinical Trials ☐ 2nd Opinion ☐ 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	☐	☐	
Cytogenetics report, including FISH	☐	☐	
Clinical notes: Summary of treatment to date, including when treatment started, delays, changes	☐	☐	
Serum protein electrophoresis(SPEP, M-Spike), immunofixation (IFE) and quantitative immunoglobulin levels (IgG/IgA/IgM), including trends	☐	☐	
24-hour urine total protein, electrophoresis (UPEP), and immunofixation (IFE)	☐	☐	
Serum free light chains assay	☐	☐	
Routine hematology and biochemistry tests (please include LDH at diagnosis/relapse if available)	☐	☐	
Initial Beta 2 Microglobulin level	☐	☐	
Reports of skeletal survey	☐	☐	
Reports of staging CT scans, MRI, functional imaging (PET scans), if performed	☐	☐	
ECHO, PFTs, if completed	☐	☐	
Cardiac Biomarkers (troponin/BNP), if performed	☐	☐	
Additional studies if performed (please specify)	☐	☐	

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