UHN Princess Margaret Cancer Centre

UHN BMT-IEC Program

Form 3A.4.4 Physician Referral Summary

Patient Name: _____ **Diagnosis:** _____

Date of Birth: _____ **MRN/OHIP:** _____

Please complete the checklist below and provide copies of all requested documents. Referring MD should assess patients within 2 weeks of requesting a consult, if the patient had a major life event (in-patient admission, ICU transfer etc.)

	Documents requested by Princess Margaret Cancer Center
Initial Consult Note	☐ Consult note ☐ N/A
Most Recent Clinical Note/Brief Summary Date of Note:_____ (mmm/dd/yyyy)	☐ Clinical note shall include: ☐ Summary of treatment received ☐ Induction dates ☐ Re-induction dates ☐ Type/number of cycles of chemotherapy ☐ Lumbar puncture/IT chemo ☐ CTs ☐ Infectious diseases/ complications ☐ Coexisting co-morbidities ☐ Notes from speciality services
Karnofsky Performance Score (KPS) KPS should be greater than 70% to proceed with transplant.	☐ 80% ☐ 90% ☐ 100%
Extramedullary Disease	☐ No ☐ Yes If yes, specify site: _____
Diagnosis Reports Date of Diagnosis:_____ (mmm/dd/yyyy)	☐ CMV status report ☐ ABO/antibody report ☐ Pathology report at diagnosis: ☐ Bone Marrow ☐ Molecular ☐ FISH/ cytogenetics ☐ Imaging reports (PET/CT) ☐ TB skin test report
Remission Reports ☐ N/A Date of Remission:_____ (mmm/dd/yyyy)	☐ Pathology report at remission: ☐ Bone Marrow ☐ Molecular ☐ FISH/ cytogenetics
Relapse Reports ☐ N/A Date of Relapse:_____ (mmm/dd/yyyy)	☐ Type/number of cycles of chemotherapy after relapse
Status at Referral	☐ CR1 ☐ CR2 ☐ CR3 ☐ PR1 ☐ PR2 ☐ Primary refractory ☐ Progressive disease ☐ LFS ☐ Other: _____
Donor Status	☐ A suitable donor has been identified ☐ A suitable donor has not been identified. Please specify reason for consult: _____

Return form by FAX # 416-946-4520 or Email: BMTAdmin@uhn.ca Phone # 416-946-4501 ext. 5082

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