The Ottawa Hospital | L'Hôpital d'Ottawa

Referral to CAR T Program

Referral Guidelines

1. This form is intended for referrals of patients meeting criteria for CAR T-cell therapy.
   Indication: ☐ DLBCL ☐ MCL ☐ ALL ☐ Clinical Trial
2. Please use the checklist on page 2 when compiling documents to be included with this referral.
3. Fax the completed form and accompanying documentation to **TOH CAR T Program, C/O TCT Office, fax no. 613-739-6816**.

Patient Information

Patient Name: _____ Date of Birth (D/M/Y): _____

Diagnosis: _____ Diagnosis Date: _____

Health Card #: _____ Disease Status: _____

Address: _____ Phone No. _____

_____ Email: _____

_____

Referral Information

Physician Name: _____

E-Mail Address: _____

Phone No: _____

Fax No: _____

Institution/Dept.: _____

Responsible Nurse/Coordinator: _____

E-Mail Address: _____

Phone No: _____

Fax No: _____

Mailing Address: _____

_____

For additional inquiries on CAR T-cell therapy referrals to TOH, call 613-737-8158.

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Patient Name:

DOB (DD/MM/YYYY):

CAR T Therapy Referral – Requirements Checklist

☐ Consult note and most recent clinical note(s)

Pathology reports at: ☐ Diagnosis ☐ Remission (OR ☐ N/A) ☐ Relapse (OR ☐ N/A)

☐ Karnofsky Performance Score (KPS) ≥70% (Specify): _____%

☐ Treatment to date, including when treatment started and response (attach additional pages if needed).

1: _____

2: _____

3: _____

☐ Cytogenetics report/molecular information, if applicable.

Central Venous Access Device: ☐ Yes ☐ No

If yes, type:_____ insertion date (Y/M/D):_____no. lumens_____

☐ Recent CT or PET imaging documenting relapsed refractory disease or bone marrow pathology

☐ Recent pulmonary function test OR ☐ not completed

☐ Recent echocardiogram OR ☐ pending

☐ Recent MRI or CT head if CNS involvement suspected OR ☐ not completed

☐ Recent blood work, including CBC, differential, electrolytes, creatinine, glucose, urea, calcium, magnesium, phosphate, albumin, LFTs, total protein, recent transmissible disease testing.

☐ Patient height ____ cm and weight ____ kg.

For patients without Ontario Health Insurance Plan (OHIP) coverage, has a provincial ministry letter been provided? ☐ Yes ☐ No (pending)

Additional Information

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