

PHOTOPHERESIS GVHD REFERRAL (v5.0 June 2011)

To facilitate Registration @ Rotherham please fully complete Page 1

To facilitate Funding Approval please send accompanying referral letter

Referring Consultant

Departmental Address

Hospital Contact Details:-

Telephone

Email

FAX

Patient Address

Patient Telephone Number

GP Name (including initial)

GP Address

GP Telephone Number

PLEASE FAX WITH A REFERRAL LETTER to 01709 830694

REFERRAL DATE _____ REFERRING HOSPITAL _____

REFERRING CONSULTANT _____

PATIENT NAME _____ NHS Number: _____

DOB: _____ AGE: _____

PRIMARY DIAGNOSIS _____ DATE _____

PRIMARY THERAPY _____

BLOOD GROUP Patient's Original Group _____ Donor Group _____

GROUP required for Transfusion Red Cells Platelets Plasma

CMV -VE Yes No IRRADIATED Yes No

TRANSPLANT TYPE _____

Auto DATE: _____ DATE: _____

SIB DATE: _____ DATE: _____

MUD DATE: _____ DATE: _____

DLI DATE: _____ DATE: _____

CONDITIONING REGIME

Reduced Dose Intensity DETAILS _____

Full Dose TBI CICLO YES NO DETAILS _____

Acute GVHD Yes No Date _____

Skin GRADE _____ Currently present Yes No

Gut GRADE _____ Currently present Yes No

Liver GRADE _____ Currently present Yes No

Treatment of Acute GvHD _____

Chronic GvHD Date _____

Skin Currently present Yes No

Liver Currently present Yes No

Mouth Currently present Yes No

Gut Currently present Yes No

Eyes Currently present Yes No

Lung Currently present Yes No

Joint Currently present Yes No

Other Currently present Yes No

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Diagnostic clinical sign of cGvHD Yes No SITE _____

Biopsy performed: Yes No SITE _____

Histology report

Please note a number of Commissioners apply rigorously the NORCOM criterion that the diagnosis of chronic graft versus host disease should be confirmed at biopsy or at least have a biopsy which is compatible with a diagnosis of chronic graft versus host disease.

Diagnosis _____ Classic Chronic GVHD Yes Overlap syndrome Yes

Current Therapy

Prednisolone	<input type="checkbox"/>	Dose	Duration
Ciclosporin	<input type="checkbox"/>	Dose	Duration
Tacrolimus	<input type="checkbox"/>	Dose	Duration
Micophenylate	<input type="checkbox"/>	Dose	Duration

Maximum Steroid Dose _____ Minimum Steroid Dose _____

***See note regarding eligibility criteria for photopheresis**

*** GvHD Eligibility Criteria** Must have BOTH major + /- minor

Major

Steroid refractory or dependant disease or unable to tolerate corticosteroid therapy	Y	N
Skin, Mucous Membrane or Liver affected by GVHD	Y	N

Minor

Biopsy proven GVHD	Y	N
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Exclusion Criteria : - Must NOT have any

Photosensitive	Y	N
Sensitive to Psoralen Compounds	Y	N
Has Aphakia	Y	N
History of Heparin induced ITP	Y	N
Neutrophil Absolute <1.0	Y	N
Platelet Count <20	Y	N
Severe diarrhoea >1000ml daily	Y	N
Pregnant	Y	N

Signature _____ Designation _____

OFFICE USE ONLY	Date referral received:	
	Clinic appointment date:	
	ECP Group informed/date:	
	Contracts informed/date:	