CAR-T – Referral Template

Lymphoma

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| **Name:**  |  | **Referral centre:**  |  |
| **DOB:**  |  | **Referring consultant:**  |  |
| **NHS no:**  |  | **Local CNS and contact details:**  |  |
| **Pt phone no:**  |  |

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| **Diagnosis and disease narrative** | **Relevant medical history/comorbidities including recent positive microbiology** |
| **Current medications** |
| **Allergies** |
| **Thrombosis history** |
| **Smoking history** |
| **Social history** |

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| ***Further information*** |
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| **Completed by:** |  | **Date:** |  |