PHOTOPHERESIS GVHD REFERRAL (v6.0 Nov 2012) Patient Name:_____

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 Name _____

Patient Address

Patient Telephone Number _____

GP Name (including initial) _____

GP Address

GP Telephone Number _____

PHOTOPHERESIS GVHD REFERRAL (v6.0 Nov 2012) Patient Name:_____

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	☐	Dose	Duration
Ciclosporin	☐	Dose	Duration
Tacrolimus	☐	Dose	Duration
Micophenylate	☐	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

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:	