|  |  |
| --- | --- |
| Referring Consultant: |  |
| Referring Health Board: |  |
| Name of person completing form: |  |
| Signature: |  |
| Date of referral: |  |
| Patient’s demographic details:(Name / D.O.B. / Address – Addressograph label preferred) |  |

## Indication for photopheresis (Please tick one box only)

*Please note that if selecting ‘Other’, then evidence of funding approval from the referring Health Board on an Individual Patient Treatment Request basis will be required before treatment can be started.*

|  |  |
| --- | --- |
| Chronic GvHD: |  |
| Acute GvHD: |  |
| Cutaneous T cell lymphoma: |  |

## Other: (please specify)

|  |
| --- |
|  |

## GvHD patients only: what was the indication for allograft?

|  |
| --- |
|  |

## Summary of patient’s clinical situation and relevant co-morbidities:

For GvHD patients, please include GRADE and SITES of GvHD, plus other relevant information such as problems related to current immunosuppression (e.g. viral reactivation, steroid myopathy)

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|  |  |
| --- | --- |
| Current therapy:(for the indication for ECP referral) |  |
| Previous therapies:(for the indication for ECP referral) |  |
| Any significant co-morbidities: |  |

## Proposed venous access

|  |  |
| --- | --- |
| Central: |  |
| Peripheral: |  |

*Please note that patients require at least one good antecubital vein for ECP to be possible using peripheral veins.*

*If the patient requires central venous access, then this will be the responsibility of the referring team.*

## N.B. REQUIRED FOR REFERRAL TO BE ACCEPTED:

I confirm that I have informed the Finance team of the patient’s Territorial Health Board of residence of this intended referral for ECP.

|  |  |
| --- | --- |
| **Please tick to confirm:** |  |