

review.

Thank you for referring your patient to Phoenix Children's Hospital. For CAR-T referrals, please call the Main PCH line at 602-933-0920 and request to speak with the on call BMT provider/Danielle Sullivan or email us at CellularTherapyReferral@phoenixchildrens.com

If possible, contact Phoenix Children's <u>immediately</u> upon relapse or recognition of refractory disease and before additional chemotherapy is given.

For a smooth referral process, please complete the following information and fax to (602) 933-2493 Attn: Danielle Sullivan, Cellular Therapy Program Coordinator.

Patient Name:			DOB:
Diagnosis:		Insurance:	Preferred Language:
Referring Facility:		Best Contact at Referring Facility:	
Parent's names & best contact phone #:			
Include the following documents in the referral packet:			
	Patient Demographic Sheet Copy of insurance card Recent History and Physical, within last 30 days Name and contact number of current social worker: Is there medical power of attorney on file? y/n		
	 □ If yes, please send copy with referral packet Treatment roadmap Prior HSCT? Y / N □ If yes, please send discharge summary 		
	Most recent hem/onc Consulting provider pr	or BMT progress note rogress notes is disease, palliative care, pulm	onology, cardiology, social
	Copy of all scan report Referring facility Danielle 1919 E.	es, within last 12 months of please also send disk of scans w of Sullivan Thomas Road CCBD of AZ 85016	/ reports to:
	Bone Marrow biopsy/most recent	aspirate reports for original dia	agnosis, relapse diagnosis, and
_ _	Lumbar Puncture reportsurgical biopsy reports Pertinent lab results: ABO typing, CMV	gy reports, cytogenetics, MRD for our orts-please include all reports. s-please include all reports. Viral titers Here in the viral titers Here in the viral titers	
	Medication list if not li		
**Phoenix Children's will handle obtaining all pathology slides for internal			