

Paediatric, Adolescent and Young Adult Clinical Service

TBI REFERRAL FORM

Please fax form to: **Attention Carmela Rooney**. Fax number: 9656 1192
If precise dates not known at time of referral please supply as soon as known.

Patient Name: _____

UR Number: _____ or place sticker

Date of birth: ___/___/___

Preferred contact numbers: _____ **Mobile:** _____

Primary transplant physician name: _____

Diagnosis: _____

Phase: (eg CR1, chronic phase) _____

Potentially significant illness: (eg connective tissue, pulmonary)

Lung function: attach, or FEV1: _____ **KCO:** _____

Previous radiotherapy: Yes / No

Treating Centre: _____

Regions irradiated: _____ **Dose:** _____

TBI request details (circle or specify):

1. Lying 12 Gy in 6 fractions, no lung shielding, twice daily for 3 days
2. Standing with lung limited to 8Gy with lung shielding
 - a) 12 Gy in 10 fractions over 4 days
 - b) 13.2 in 11 fractions over 4 days

Testis boost (4Gy in 2 fractions during TBI)? Yes / No

Does the child require GA Yes / No

Chemotherapy regimen: _____

Dates of planned chemotherapy: ___/___/___ to ___/___/___

Dates requested for TBI: ___/___/___ to ___/___/___

Does donor location limit flexibility with dates? Yes / No

Please note: if possible, perform last LP and bone marrow on the Monday of the week prior to planned TBI and notify change of treatment plan as soon as possible if relapse detected.