The Rotherham
NHS Foundation Trust

PHOTOPHERESIS GVHD REFERRAL

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

(inc telephone contact details)

GP Name

GP Address

& contact telephone number

The Rotherham
NHS Foundation Trust

PHOTOPHERESIS GVHD REFERRAL contd

Patient Name:___________________

PLEASE FAX WITH A REFERRAL LETTER to 01709 830694

REFERRAL DATE ………………… **REFERRING CONSULTANT** ………………

REFERRING HOSPITAL …………………………………………………………….

PATIENT NAME………………………….. **NHS Number:** …………………………

DOB: …………………………………………. **AGE:** ………………………………….

PRIMARY DIAGNOSIS ………………… **DATE** ……………………………….

PRIMARY THERAPY …………………………………………………………….

BLOOD GROUP Patient Original Group …………………….. Donor Group …………………..

Group required for transfusion Red cells ☐ **Platelets** ☐ **Plasma** ☐

CMV –ve Yes/No **Hep E negative 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 ……………………………………………………………………………………………..

……………………………………………………………………………………………………..

…………………………………………………………………………………………………….

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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

Gut ☐ Currently present Yes No

Liver ☐ Currently present Yes No

Eyes ☐ Currently present Yes No

Lung ☐ Currently present Yes No

Joint ☐ Currently present Yes No

Other(please state) ………………………… Currently present Yes No

Diagnostic clinical sign of cGvHD Yes ☐ No ☐ SITE ……………………

Biopsy performed: Yes ☐ No ☐ SITE ……………………

Histology report ……………………………………………………………………………………..

……………………………………………………………………………………………………..

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**

GvHD Eligibilty Criteria **Must have BOTH major+/- minor**

Major

Steroid refractory or dependant disease or unable to tolerate corticosteroid therapy **Yes** ☐ **No** ☐

Skin, Mucous Membrane or Liver affected by GvHD **Yes** ☐ **No** ☐

Minor

Biopsy proven GvHD **Yes** ☐ **No** ☐

Exclusion Criteria – must NOT have any

Photosensitive **Yes** ☐ **No** ☐

Sensitive to Psoralen compounds **Yes** ☐ **No** ☐

Has Aphakia **Yes** ☐ **No** ☐

History of Heparin Induced ITP **Yes** ☐ **No** ☐

Neutrophil Absolute <1.0 **Yes** ☐ **No** ☐

Platelet count <20 **Yes** ☐ **No** ☐

Severe diarrhoea >1000ml daily **Yes** ☐ **No** ☐

Pregnant **Yes** ☐ **No** ☐

Signature ……………………………………….. **Designation** ……………………………….

OFFICE USE ONLY	**Date referral received**	
	Clinic appointment date:	
	ECP Grouop informed/date	
	Contracts informed/date	

Date referral received: