Center for
Blood and Marrow Outpatient Transplant

3655 Vista Avenue • 2nd Floor-North
St. Louis, MO 63110 (314) 268-7700

FAX

Subject: Records for a BMT Consult "Urgent"

Date:________________

TO: Stephanie Scheuttler or Chris Rimkus (*Fax: 314-268-7711*)

From:____

*Number of pages being sent:*_____________________

Comments:

Records requested:

- Copy of insurance card and face sheet (so we can assure that we initiate transplant eval approval)
- Office notes
- All biopsy results including bone, bone marrow, lymph node as applicable
- Imaging r/t disease (PET scan, bone survey, CT scan, MRI)
- All disease relevant labs, including initial and follow up (i.e. for lymphoma initial LDH; for myeloma, initial beta 2 microglobulin, LDD, SPEP, light chains, immunofixation, 24 hr urine with UPEP)
- Comorbidity information (i.e. heart/lung/kidney testing that may have been done in the past)
- Suggestions for timing of visit if the patient has any preferences/special circumstances (getting chemo; needs driver/ride)

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Center for
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Bone Marrow Transplant Consult Request Form

Send to BMT/Scheduler at time of scheduling *Fax: 314-268-7711*

Patient Name:_______________________________DOB:_______________________

Patient phone number:____

Insurance information:____

Is patient aware that they are going to be contacted by BMT clinic Yes No

Preferred Dates to be scheduled (based on pt schedule and coordination- needs to be M, Tu, Th afternoon if possible):__________________________________

- ◯ Urgent (within 1 week)
- ◯ Non-Urgent (within 2-3 weeks)

Disease:____

Referring Physician:____

Requesting specific BMT Attending:___________________________

Additional information that is relevant to scheduling.

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