

Thank you for referring your patient to Phoenix Children's Hospital. For CAR-T referrals, please call the Cellular Therapy Referral Line at (480) 826-4251 or email our team at CellularTherapyReferral@phoenixchildrens.com. If possible, contact Phoenix Children's immediately 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: Michelle Gillard, 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 Referral Note 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		
	All treatment roadmap Prior HSCT? Y / N ☐ If yes, please so	os end discharge summary	
	Most recent hem/onc of Consulting provider properties. ☐ Including infection	or BMT progress note rogress notes is disease, palliative care, pulm	onology, cardiology, social
	□ Referring facility ■ Michello 1919 E.	ogy/psychiatry. s, within last 12 months y please also send disk of scans w/ e Gillard Thomas Road CCBD x, AZ 85016	reports to:
	Bone Marrow biopsy/most recent	aspirate reports for original dia	
	Lumbar Puncture repo	gy reports, cytogenetics, MRD for our orts-please include all reports. s-please include all reports. Viviral titers	eacn marrow.
<u> </u>	☐ If applicable: gen Medication list if not li	netic testing, disease related labs i sted in clinical note vill handle obtaining all patholo	