SENSITIVE: PERSONAL

APPLICATION FOR FUNDING UNDER THE BONE MARROW TRANSPLANT PROGRAM

To be completed by the Bone Marrow Transplant Coordinator, or other appropriate person.
Please print clearly and provide all details requested. If there are any changes to the arrangements described below, the Department of Health must be informed as soon as possible.

Patient's personal details:			
Title:	First Name:	Surname:	
Postal Address:			
Suburb:	State/Territory:	Postcode:	
DOB:	Gender:	☐ Male ☐ Female	☐ Unspecified
Medicare No:			
If patient is a child (under 16 years), please list parents'/guardian's details:			
Title:	First Name:	Surname:	
Title:	First Name:	Surname:	
Postal Address:			
Suburb:	State/Territory:	Postcode:	
Is this the first application for funding under the BMTP for this patient?		☐ Yes	☐ No

Contact person/BMT Hospital Coordinator details:		
Title:	First Name:	Surname:
Phone:	Mobile:	
Email address:		

Treating consultant details:		
Title:	First Name:	Surname:
Phone:	Mobile:	
Email address:		

Hospital/treatment centre details:		
Institution:	Department:	
Postal Address:		
Suburb:	State/Territory:	Postcode:

Patient clinical details:		
Diagnosis:	Date of diagnosis:	
Treatment to date:		
Proposed treatment plan:	Date of transplant:	
Is the patient's diagnosis on the Condition's List?	☐ Yes	☐ No
*If **no**:* *- Please provide literature that supports use of the treatment for this condition.* *- Has this treatment been recommended following consideration by two or more relevant medical specialists or a multidisciplinary team?*	☐ *Yes*	☐ *No*

Type of treatment the patient will receive:		
☐ Bone Marrow	☐ Single Cord Blood Unit	☐ Peripheral Blood Stem Cells
☐ Donor Lymphocytes	☐ Double Cord Blood Unit	

A suitable donor must not be available in Australia:		
1(a): Is the donor related or unrelated to the applicant?	☐ Related	☐ Unrelated
1(b): What is the origin of the related donor or donation/s?		

The treatment must be significantly life-extending and potentially curative for the applicant and there must be a real prospect of success:	
What is the likelihood of the patient's survival at 12 months without this treatment?	%
What is the likelihood of the patient's survival at 12 months with this treatment?	%

The proposed treatment must be accepted as a clinically appropriate form of treatment by the medical profession:

Is the treatment accepted as a standard form of treatment for the patient's condition? ☐ Yes ☐ No

*If **no**, please provide supporting comments below:*

Additional comments (please attach further information if necessary):

Consent/Certification:

I, _____ (BMT Coordinator/Treating Consultant), hereby state that all information provided in this application is true and correct to the best of my knowledge. I certify that the patient has been provided with accurate information about the Bone Marrow Transplant Program and is aware that their personal information will be provided to the Department of Health to determine eligibility for funding and to administer financial payments under the BMTP. I certify that the patient or their legal guardian understands and has consented to the collection and use of their personal information for this purpose and to any disclosures by the Department of Health to third parties for this purpose, noting the Department is unlikely to disclose personal information to overseas parties.

Name:	Signed:
Position:	Date:

Fax to **(02) 6289 7630** (BMTP Coordinator, Department of Health)
Email: **bone.marrow.transplant.program@health.gov.au**