State of Illinois
Department of Healthcare and Family Services

CAR-T Cell Therapy-Outcome Reporting Form

Hospital: _____ Today's Date: _____

Patient Name: _____ DOB: _____ RIN: _____

CAR-T Cell Therapy-Outcome Reporting Form ☐ 6 Months ☐ 12 Months

ADMITTING DIAGNOSIS (If hospitalized):

DATE OF ADMISSION: _____ DATE OF ADMISSION: _____

PRE-TREATMENT DIAGNOSIS (if other than admitting Dx)

TREATMENT COMPLICATIONS-During and After-treatment (if any):

ASSESSMENT OF PATIENT's CURRENT CONDITION & PROGNOSIS:

PERSON COMPLETING FORM:

Name: _____ Title: _____

Telephone (include area code): _____

Email: _____

_____
Authorized Official Signature, Physician/ Director

Complete and return ORIGINAL, SIGNED form with Hospital Discharge Summary or Most Recent progress notes to:

Via US Mail to: Illinois Department of Healthcare and Family Services
Division of Medical Programs, Pharmacy Program
607 E Adams St, 4th FL, **Springfield**, Illinois 62701-1634

Or **Via E Mail attachment to**: HFS.HospitalDrugsPA@Illinois.gov