CAR T-CELL THERAPY WALLET CARD

THIS PATIENT HAS RECEIVED **CAR T-CELL THERAPY** FOR THE TREATMENT OF **NON-HODGKIN LYMPHOMA**

Name of CAR T-cell treating oncologist: _____

Hospital and associated clinic name: _____

Office: _____

After-hours: _____

Therapy name: _____

Therapy batch/lot #: _____

Date of infusion: _____

Local oncologist: _____

Phone: _____

Emergency contact: _____

Phone: _____

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