

ViaCord ID: _____



ViaCord's Newborn Stem Cell Donor Program

Medical Referral Form

Thalassemia

Patient Name _____ Patient Gender: M / F _____ Patient Date of Birth _____ Patient Weight in Kg. _____

Mother's Name _____ Mother's Phone Number _____ Due Date _____

Pregnancy is a FULL sibling (Please check box to confirm)

MEDICAL INFORMATION

Genotype

β major E - β + E - β^0 α - major Hb H other than intermediate

Surgical History

Splenectomy: No Yes, age: _____

Infections History

HCV: No Yes Not Tested

Transfusion History

Chronic transfusion: No Yes, every _____ weeks
RBC alloantibodies: None Yes (circle): Kell E e C c other(s) _____
Approx. Total RBC transfusions: None 1-10 >10 >50

Medications

Any hormone replacement: No Yes
HCV treatment: No Yes
Iron chelation therapy: No Yes, current dose is: _____ every: _____

Other medication(s): _____

Complications Related to Thal or Hemochromatosis

Hepatomegaly: No Yes (circle): <2cm >2cm
Portal fibrosis: No Yes, age diagnosed: _____ grade: _____
Cirrhosis: No Yes, age diagnosed: _____ grade: _____
Cardiac dysfunction: None Yes, age diagnosed: _____ describe: _____
Gonadal failure: None Yes, age diagnosed: _____ describe: _____
Diabetes mellitus: None Yes, age diagnosed: _____ describe: _____

Summary/Comments (Please add extra pages if necessary)

TREATING PHYSICIAN INFORMATION

Physician Name _____ Specialty _____

Phone _____ Email _____

Fax _____ Hospital _____

Physician Office Address _____ City _____ State _____ Zip Code _____

Other Contact Name (RN/NP) _____ Other Contact Phone _____

(Please check box to agree)

It is my medical judgment that this patient has a condition that may be treated with a hematopoietic stem cell transplant using sibling cord blood stem cells

Reporting Provider Name (Print) _____ Signature _____ Date _____

Please return completed form to ViaCord.
Fax: 781-240-8427 or Email: SiblingConnection@ViaCord.com