ViaCord ID:_____

Medical Referral Form

Sickle Cell Disease

THE SIBLING CONNECTION
ViaCord's Newborn Stem Cell Donor Program

PATIENT NAME | PATIENT GENDER: M / F | PATIENT DATE OF BIRTH | PATIENT WEIGHT IN KG

MOTHER'S NAME | MOTHER'S PHONE NUMBER | DUE DATE:

DIAGNOSIS | DATE OF DIAGNOSIS

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

MEDICAL INFORMATION

Genotype

☐ S-S ☐ S- β + ☐ S- β⁰

Surgical History

Splenectomy: ☐ No ☐ Yes, age: _____

Choleycystemctomy: ☐ No ☐ Yes, age: _____

Transfusion History

Chronic transfusion: ☐ No ☐ Yes, every _____ weeks Indication:

RBC alloantibodies: ☐ None ☐ Yes (circle): Kell e C c other(s)_____

Total RBC transfusions: ☐ None ☐ 1-10 ☐ >10 ☐ >50

Medications

Hydroxyurea: ☐ No ☐ Yes

Desferal: ☐ No ☐ Yes

Other medication(s): _____

Complications Related to Sickle Cell or Hemochromatosis

Splenic sequestration:	☐ No	☐ Yes	Osteonecrosis:	☐ No	☐ Yes
Aplastic crisis (Parvo B19):	☐ No	☐ Yes	Chronic leg ulcers:	☐ No	☐ Yes
Stroke:	☐ No	☐ Yes	Recurrent priapism:	☐ No	☐ Yes
Sickle nephropathy:	☐ No	☐ Yes	Abnormal TCD:	☐ No	☐ Yes

Hospitalized for pain: ☐ No ☐ Yes If yes, avg. no. episodes/year: _____

Acute chest syndrome: ☐ No ☐ Yes If yes, no. episodes: _____

Sepsis: ☐ No ☐ Yes If yes, no. episodes: _____

Other: _____

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 | SIGNATURE DATE

PLEASE FAX COMPLETED FORM TO 781-663-8099 OR EMAIL TO SIBLINGCONNECTION@VIACORD.COM