ViaCord ID:________________________

Medical Referral Form

Sickle Cell Disease

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- β°

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

Aplastic crisis (Parvo B19): ☐ No ☐ Yes

Stroke: ☐ No ☐ Yes

Sickle nephropathy: ☐ No ☐ Yes

Osteonecrosis: ☐ No ☐ Yes

Chronic leg ulcers: ☐ No ☐ Yes

Recurrent priapism: ☐ 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

☐ **It is my medical judgment that this patient has a condition that may be treated with a sibling newborn stem cell transplant.**

REPORTING PROVIDER NAME (PRINT)	SIGNATURE	SIGNATURE DATE

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