ViaCord ID:_____

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 - β⁰ ☐ 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 | SIGNATURE DATE

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