ViaCord ID:_____

# Medical Referral Form

**Thalassemia**

THE SIBLING CONNECTION
ViaCord's Sibling Cord Blood Donor Program

Patient Name (PRINT) | Patient Gender: M / F | Patient Date of Birth | Patient Weight in Kg.

Mother's Name (PRINT) | Mother's Phone # | Mother's Email | 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 Thal Intermedia

### 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
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: _____

**Comments** (Please add extra pages if necessary)

_____

## TREATING PHYSICIAN INFORMATION

Physician Name | Specialty

Phone | Email (Required)

Fax | Hospital

Physician Office Address | City | State | Zip Code

Other Contact Name (RN/NP) | Other Contact Phone | Email

**By signing below I attest that 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**