

Medical Referral Form

Hemoglobinopathy

Patient Name (Print)	Patient Gender M / F	Patient Date of Birth	Patient Weight in Kg.
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Mother's Name (Print)	Mother's Phone #	Mother's Email	Due Date
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☐ 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 Thal Intermedia

☐ S-S ☐ S- β + ☐ S- β^0 ☐ Other Transfusion Dependent Hemoglobinopathy: _____

Transfusion History

Chronic transfusion: ☐ No ☐ Yes, every ____ weeks

RBC alloantibodies: ☐ No ☐ Yes, (circle) Kell E e C c Other(s) _____

Approximate total RBC transfusions: ☐ None ☐ 1-10 ☐ >10 ☐ >50

Medications

☐ Hydroxyurea ☐ Iron chelation therapy Current dose: _____

Other medication(s): _____

Complications Related to Hemoglobinopathy (check all that apply)

☐ Hepatomegaly ☐ Portal fibrosis ☐ Hospitalized for pain ☐ Sepsis ☐ Stroke ☐ Cirrhosis
☐ Cardiac dysfunction ☐ Splenic Sequestration ☐ Sickle nephropathy ☐ Acute Chest Syndrome
☐ Gonadal failure ☐ Diabetes mellitus ☐ Aplastic Crisis

Number of Veno-Occlusive Crisis or associated complications: _____

Comments (Please add extra pages if necessary)

TREATING PHYSICIAN INFORMATION

Physician Name	Specialty
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Phone	Email (Required)
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Fax	Hospital
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Physician's Office Address	City	State	Zip Code
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Other Contact Name (RN/NP)	Other Contact Phone	Email
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Name / contact information for any Clinic, Social worker or other system-based support for the families of children with this diagnosis.

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