

Medical Referral Form

Oncology

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**Diagnosis**

Leukemia: ☐ ALL ☐ AML ☐ CML ☐ JMML ☐ CMML ☐ Secondary AML

Lymphoma: ☐ Hodgkin's ☐ Non-Hodgkin's ☐ Burkitt's ☐ Lymphomatoid granulomatosis

Other: ☐ Myelodysplastic syndrome ☐ Myelofibrosis

☐ Other diagnosis: _____

Date of diagnosis: _____ Cytogenetics: _____

Other characteristics (e.g., risk group, staging, etc.): _____

Treatment

Most Recent Treatment Regimen: ☐ None ☐ CCG ☐ POG ☐ COG Other: _____

On or Per Clinical Trial Protocol #: _____

History

Present status: ☐ Remission ☐ Relapse ☐ Other: _____

Clinical relapses: ☐ 0 ☐ 1 ☐ 2 ☐ 3

Molecular relapses: ☐ N/A ☐ 1 ☐ 2 ☐ 3

Summary/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