ViaCord ID:

Medical Referral Form

Hemoglobinopathy

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 - β° ☐ α - major ☐ Hb H ☐ Other Thal Intermedia

☐ S-S ☐ S- β + ☐ S- β° ☐ 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

Phone | Email (Required)

Fax | Hospital

Physician's Office Address | City | State | Zip Code

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

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 (Handwritten not Digital) | Date

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