



**Entrance into the International Fanconi Anemia Registry**

*(To be obtained from the Study participant or a parent or a legal guardian)*

Name of the participant \_\_\_\_\_

**INFORMATION ABOUT THE PERSON FILLING OUT THIS FORM:**

Name of the person providing information: \_\_\_\_\_

Relationship to the participant \_\_\_\_\_

Contact information of person providing information:

Home Telephone \_\_\_\_\_ Mobile Telephone \_\_\_\_\_

Email address: \_\_\_\_\_

What is the best way to contact you? Email, phone: \_\_\_\_\_

**INFORMATION ABOUT THE PARTICIPANT:**

Gender \_\_\_\_\_

Date of birth \_\_\_\_\_

Place of birth \_\_\_\_\_

Race \_\_\_\_\_ (American Indian/Alaska Native, Asian, African American, Native Hawaiian or Pacific Islander, White)

Hispanic or Latino? Y/N

Address \_\_\_\_\_

Street City State Zip

Home Telephone \_\_\_\_\_ Mobile Telephone \_\_\_\_\_

Email \_\_\_\_\_ Languages spoken \_\_\_\_\_

Sometimes families move, would you be willing to provide an alternate contact so we may reach your family? Please note that this person should not be living with you.

Alternate contact:

Name: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_

Email address: \_\_\_\_\_

**INFORMATION ABOUT PHYSICIANS:**

**Pediatrician/primary care physician:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

**Hematologist:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

**Other physicians:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

Name: \_\_\_\_\_



Address: \_\_\_\_\_

Phone number: \_\_\_\_\_