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: _____

Please use additional pages if you/your child has seen other physicians