Rockefeller University Institutional Review Board
IRB NUMBER: AAU-0112
IRB APPROVAL DATE: 02/04/2017
IRB EXPIRATION DATE: 02/03/2018

REQUISITION FORM - SAMPLES FOR IFAR REGISTRY

Indication for study: Entrance into International Fanconi Anemia Registry (IFAR)
Please read 'collection and shipment instruction' form before obtaining any samples.
For questions, please call our Study Coordinator at: 212-327-8612, or
our Laboratory Manager, Frank Lach, at: 212-327-8862

PATIENT NAME:______________________________ HOSPITAL NO.________
BIRTHDATE:________________________________sex:______ height:_______ weight:_____
REFERRING PHYSICIAN:____
PHYSICIAN'S CONTACT INFORMATION:
Address: ____
Telephone #: (___)______________ Fax #: (___)______________

For blood samples (in green top sodium heparin tubes):
Date drawn: ________________ Time: ______ Amount:_________ WBC :_________

For cultured or frozen fibroblasts:
Date Set Up: __________ Site of biopsy: ___________
Are these primary cells? Y/N If not, please specify: ______________________________________
Are cells cultured or frozen? __________________ Date sent: ______________

For buccal swabs:
Date swabbed: ____________ # of swabs provided:________ Date sent to RU: __________

For genomic DNA samples:
Date Extracted:____________ Method: ___________________________________
Amount: ______(µg) Concentration:_______(µg/mL)

~~Does patient have diagnosis of Fanconi anemia? Yes/No~~

If Yes, age at dx: ________ Does patient have aplastic anemia? Yes/No
Please circle any of the following abnormalities that apply:

thumb and radius	other skeletal	cardiac
cafe au lait spots	kidney	GI
genital	urinary tract	eye, microphthalmia
ear,deafness	growth retardation	learning disabilities

OTHER____

If No, relationship to person with Fanconi anemia (please circle one):

Parent of FA patient	Sibling of FA patient
Grandparent of FA patient	Other: ______________________________

To my knowledge, this patient has consented to be in this study. I have informed the patient that this sample is being sent for research and we may or may not receive results. If results are obtained, the patient understands that results would need to be confirmed in a clinical laboratory. I have also informed the patient that this research may involve genetic testing and that the results of this test could have implications for his or her family.

SIGNATURE OF ORDERING INDIVIDUAL ______________________________ DATE: ______________________