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): For adults and pediatric patients over age 5, we require 10cc. For newborns we would like at least 3cc. For all other pediatric patients we need at least 5cc.

Date drawn: ____________ Time: _______ Amount:___________ WBC :___________

For blood samples for RNA extraction: Blood should be drawn into 2.5 ml PAXgene Blood RNA tubes. Regardless of the age and FA status of the individual, we require the 2.5 ml amount.

Date drawn: ____________ Time: _______ Amount:___________

For cultured or frozen fibroblasts:
Date Set Up: ____________ Site of biopsy: _____________
Are these primary cells? Y/N If not, please specify: ____________________________ Date sent: _____________
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: ________________________________

11/19/2018
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: ___________________________