Rockefeller University Institutional Review Board
IRB NUMBER: AAU-0112
IRB APPROVAL DATE: 07/13/2015
IRB EXPIRATION DATE: 03/11/2016

REQUSITION 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: _____