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: 212-327-8613, 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: _____
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:_____(□g) Concentration:_____(□g/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:** _____