ViaCord ID:_____

Medical Referral Form

Sickle Cell Disease

THE SIBLING CONNECTION
ViaCord's Newborn Stem Cell Donor Program

Patient Name (PRINT) | Patient Gender: M / F | Patient Date of Birth | Patient Weight in Kg.

Mother's Name (PRINT) | Mother's Phone # | Mother's Email | Due Date

Diagnosis | Date of Diagnosis

☐ **Pregnancy is a FULL sibling** (Please check box to confirm)

MEDICAL INFORMATION

Genotype

☐ S-S ☐ S- β + ☐ S- β⁰

Surgical History

Splenectomy: ☐ No ☐ Yes, age: _____

Choleycystemctomy: ☐ No ☐ Yes, age: _____

Transfusion History

Chronic transfusion: ☐ No ☐ Yes, every _____ weeks Indication:

RBC alloantibodies: ☐ None ☐ Yes (circle): Kell e C c other(s)_____

Total RBC transfusions: ☐ None ☐ 1-10 ☐ >10 ☐ >50

Medications

Hydroxyurea: ☐ No ☐ Yes

Desferal: ☐ No ☐ Yes

Other medication(s): _____

Complications Related to Sickle Cell or Hemochromatosis

Splenic sequestration:	☐ No	☐ Yes	Osteonecrosis:	☐ No	☐ Yes
Aplastic crisis (Parvo B19):	☐ No	☐ Yes	Chronic leg ulcers:	☐ No	☐ Yes
Stroke:	☐ No	☐ Yes	Recurrent priapism:	☐ No	☐ Yes
Sickle nephropathy:	☐ No	☐ Yes	Abnormal TCD:	☐ No	☐ Yes

Hospitalized for pain: ☐ No ☐ Yes If yes, avg. no. episodes/year: _____

Acute chest syndrome: ☐ No ☐ Yes If yes, no. episodes: _____

Sepsis: ☐ No ☐ Yes If yes, no. episodes: _____

Other: _____

Summary/Comments (Please add extra pages if necessary)

TREATING PHYSICIAN INFORMATION

Physician Name | Specialty

Phone | Email (Required)

Fax | Hospital

Physician's Office Address | City | State | Zip Code

Other Contact Name (RN/NP) | Other Contact Phone

(Please check box to agree)

☐ **It is my medical judgment that this patient has a condition that may be treated with a hematopoietic stem cell transplant using sibling cord blood stem cells**

Reporting Provider Name (PRINT)	Signature	Date

Please return completed form to ViaCord.
Fax: 781-240-8427 or Email: SiblingConnection@ViaCord.com