EWOG MDS - 2006

Invoice Form for Research Material

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Physician: ______________________________

Institution: ______________________________

Address: ______________________________

Email: ______________________________

(arrival of sample will be confirmed by email)

Phone: ____________________ Fax: ____________________

Patient Name: ____________________ First Name: ____________________

Date of Birth: |__|__||__|__||__|__|

Presumptive Diagnosis: ______________________________

Clinical Signs

Splenomegaly	☐ Yes	☐ No
Hepatomegaly	☐ Yes	☐ No
Lymphadenopathy	☐ Yes	☐ No

Additional Findings ______________________________

Hematological Findings

Hb (g/dl)	________	MCV (fl)	________
WBC (10^9/L)	________	Platelets (10^9/L)	________
Reticulocytes (‰)	________		

Transfusions within the last 4 weeks ☐ no ☐ yes, ☐ Ery. Tx ☐ Plt. Tx

Material Sent

- ☐ heparinized bone marrow (min. 3-5 ml) (please enclose 1 unstained bone marrow smear) — Date |__|__||__|__||__|__|
- ☐ heparinized blood (min. 3-5 ml) (please enclose 1 unstained blood smear) — Date |__|__||__|__||__|__|
- ☐ hairs with roots (for all JMML patients, at least 10 hairs) — Date |__|__||__|__||__|__|
- ☐ fibroblasts/ skin biopsy — Date |__|__||__|__||__|__|

Intended analyses

- ☐ JMML: Mutational analysis for *RAS, PTPN11* and *CBL*
- ☐ Other: ______________________________

Date |__|__||__|__||__|__| Stamp

Signature ____________________