EWOG MDS - 2006

Requisition 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: |__|__||__|__||__|__| (dd.mm.yy)

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)	Date |__|__||__|__||__|__| (dd.mm.yy)
☐ heparinized blood (min. 3-5 ml)	Date |__|__||__|__||__|__| (dd.mm.yy)
☐ 1 unstained bone marrow smear + 1 unstained blood smear (mandatory for initial diagnostics)	Date |__|__||__|__||__|__| (dd.mm.yy)
☐ hairs with roots for all JMML/ molecular genetic MDS (at least 10 hairs)	Date |__|__||__|__||__|__| (dd.mm.yy)
☐ fibroblasts/ skin biopsy	Date |__|__||__|__||__|__| (dd.mm.yy)

Intended analyses

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

☐ Other: _____

Date |__|__||__|__||__|__| Stamp Signature _____