EWOG-MDS/SAA **Invoice Form for Morphology**

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Please fill in here:
Patient label/ information (name, date of birth, ...)

Presumptive diagnoses / symptoms:

Clinical signs

Splenomegal	☐ Yes	☐ No
Hepatomegaly	☐ Yes	☐ No
Lymphadenopathy	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No

T**herapy given:** _____ _____

Transfusions within the last 4 weeks ☐ No

☐ Yes: ☐ Erythrocytes ☐ Platelets

Hematological findings		**Bone Marrow**	**Blood**
Date		(dd.mm.jjjj)	(dd.mm.jjjj)
Leukocytes	(10^9/l)		
HB *(unit)*	☐ g/dl ☐ mmol/l		
Erythrocytes	(10^{12}/l)		
MCV	(fl)		
Retikulocytes	(‰)		
Platelets	(10^9/l)		

Material

	Date (dd.mm.jjjj):		Date (dd.mm.jjjj):
☐ hep. KM (2-3 ml)		☐ core biopsy	
☐ KM-Smears (10 A.)		☐ hairfollicel (10-15)	
☐ hep. blood (5-10 ml)		☐ fibroblasts/ skinbiopsy	
☐ blood smears (10 A.)		☐ oral mucosa	

Local Center (Clinic adress)

Name: _____

For questions, Phone: _____
Fax: _____

_____
Date, Signature

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