EWOG-MDS
EWOG-SAA

Requisition Form - Mutational Analysis

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Physician: _____

Institution: _____

Address: _____

Email: _____

Phone: _____ Fax: _____

Patient Name: _____ First Name: _____

Date of Birth: |__|__||__|__||__|__ (dd.mm.yy) **Gender**: ○ male ○ female ○ diverse

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 (‰)	_____	HbF (%)	_____

Transfusions within the last 4 weeks ☐ no ☐ yes, please speyify: ☐ 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 (at least 10 hairs) **AND** 2 buccal swabs (for JMML/ MDS)	Date |__|__||__|__||__|__| (dd.mm.yy)
☐ fibroblasts / skin biopsy (in culture medium)	Date |__|__||__|__||__|__| (dd.mm.yy)

Intended analyses

☐ JMML: Mutational analysis
☐ Other: _____

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