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 _____

In general, a report will be available within 3 weeks. It will be faxed (provided fax number given) with initials only. The original report will be sent by mail.