

Patient

Name: _____
First Name: _____
Date of birth: _____
Diagnosis: _____

Coordinating Study Center

Center for Pediatrics and Adolescent Medicine
Clinic IV: Div. of Pediatric Hematology and Oncology
Mathildenstraße 1, 79106 Freiburg, Germany
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+49-(0)761/270-45150 (Lab)
Fax: +49-(0)761/270-46230
Website: <http://www.ewog-mds.org>
E-Mail: ewog-mds@uniklinik-freiburg.de

Physician: _____
Institution: _____
Address: _____
Email: _____ (arrival of sample will be confirmed by email)
Phone: _____ Fax: _____

Clinical Signs

| | | |
|-----------------|------------------------------|-----------------------------|
| Splenomegaly | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hepatomegaly | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lymphadenopathy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Additional Findings _____

Hematological Findings

| | | | |
|-----------|-------|--------------------------------|-------|
| Hb (g/dl) | _____ | Reticulocytes (‰) | _____ |
| Htk (%) | _____ | Platelets (10 ⁹ /l) | _____ |
| MCV (fl) | _____ | WBC (10 ⁹ /l) | _____ |

Transfusions (within the last 4 weeks) No Yes, Red Blood Cells Platelets

Material Sent

- Heparinized bone marrow (min. 3-5 ml) Date _____
(please enclose 1 unstained bone marrow smear)
- Heparinized blood (min. 3-5 ml) Date _____
(please enclose 1 unstained blood smear)
- Skin biopsy (in 0,9% NaCl or RPMI-Medium) Date _____
- Hair follicles (at least 10 follicles in a sterile tube) Date _____

Requested analyses

- JMML: Mutational analysis for specific exons of *NRAS*, *KRAS*, *PTPN11* and *CBL*
- Other: _____

Caution: To perform mutational analysis, we require your signed consent. Both the information leaflet and the informed consent form are available at: www.ewog-mds.org/invoice_forms

Date ____|____|____|____|____|____|____|____| Stamp Signature _____

In general, a report will be made available within 3 weeks.