AAMDSIF Patient Referral Form

Please complete, or ask the patient to complete, the following information and send to the Aplastic Anemia and MDS International Foundation by fax, email, or mail to the address below. Upon receipt, an AAMDSIF patient information specialist will reach out to the patient and send resource information. Patient information provided will remain confidential; however, names will be added to our patient database and mailing list. For any questions, please contact the foundation at (301) 279-7202 ext. 140.

Patient's First Name:	Last Name:
Street Address:	City/State/Zip Code:
Primary Phone Number:	Email:
Date of Birth:	Date of Diagnosis:
If minor, Parent/Guardian First and Last Name:	

Diagnosis: (check one of the following)

- ☐ Aplastic Anemia
- ☐ Acute Myeloid Leukemia (AML)
- ☐ Chronic Myelomonocytic Leukemia (CMML)
- ☐ Myelodysplastic Syndromes (MDS)
- ☐ Myeloproliferative Neoplasms (MPN)
- ☐ MDS/MPN
- ☐ Paroxysmal Nocturnal Hemoglobinuria (PNH)
- ☐ Pure Red Cell Aplasia (PRCA)
- ☐ Graft Versus Host Disease (GVHD)
- ☐ Juvenile Myelomonocytic Leukemia (JMML)
- ☐ Other

Healthcare professional making the referral:

Name ____________________ Phone ____________________

Institution ____________________ Email ____________________

Signature ____________________ Date ____________________

Patient confidentiality agreement: *To ensure patient privacy protection as part of the Health Insurance Portability and Accountability Act (HIPAA) and to provide patients with control over what personal information is used and disclosed,*

I, ______________________________, agree to have the above information released to the Aplastic Anemia and MDS International Foundation

Signature of patient/guardian: ____________________ *Date:* ____________________

Aplastic Anemia and MDS International Foundation
4330 East West Highway, Suite 230, Bethesda, MD 20814
301-279-7202 ext. 140, Fax: 240-534-2231
Email: help@aamds.org
www.aamds.org