Fanconi Anemia Registry 01
FAR01 HSCT

➔ The HSCT should be fully documented in the PRSZT!

Patient initials (first name / last name) |__|__|

Quarter and year of birth (q/yyyy) |__| / |__|__|__|__|

Sex: ☐ male ☐ female

Patient Identification Number |_____|

Transplantation Center |_____|

Date of SCT |__|__||__|__||__|__| (dd/mm/yy)

Number of SCT |_____| Type of SCT ☐ autologous ☐allogeneic

Further comments: _____

Referring physician name and institution |_____|
Address |_____|
Telephone and fax |_____|
email |_____|

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