BiO-ID |__|__|__|__|__|__| Date of birth: |0|1|/|0|1|/|__|__|__|__| month year Study: _____ Study-ID: |__|__|__|__|__|__| (if applicable) Please tick: Stationär/Inpatient ☐ Ambulant/Outpatient ☐ § 116b SGB V ☐ Patient has private health insurance? ☐ Yes ☐ No	**Hannover Medical School** **Department of Hematology, Hemostasis, Oncology and Stem Cell Transplantation** **Prof. Dr. med. Florian Heidel** **Laboratory for Leukemia Diagnostics** Carl-Neuberg Strasse 1 Gebäude K5, Ebene 1, Raum 3130 30625 Hannover Phone: +49 (0)511-532-3609 Fax: +49 (0)511-532-3611 E-Mail: hae.leukaemiediagnostik-labor@mh-hannover.de **AMLSG Clinical Trials Office (Ulm)** Phone (Mo-Fr): +49 (0)731 500-56072 Phone (Weekend): +49 (0)173 349-2447

Material Delivery Shipment Form for: AMLSG-BiO

Diagnosis (please tick):	☐ AML	☐ Relapse	☐ MDS/AML (according ICC 2022)
First Material Shipment (please tick): ☐		☐ Refractory AML	
Time Point (please tick):	☐ Diagnosis ☐ Screening at study entry	☐ End of induction therapy (time of documented CR/CRh/CRi)	☐ End of cycle (optional): _____ ☐ Follow-Up (optional) ☐ Refractory disease / Relapse
Required amount of material:	➢ Bone marrow: ≥10ml (molecular) (Na-EDTA) ➢ Bone marrow: ≥10ml (cytogenetics) (Na-Heparin) ➢ Bone marrow: ≥10ml (flow cytometry ->Ulm)* (Na-Heparin) ➢ Blood: 20-40 ml (molecular) (Na-EDTA) ➢ Blood: 5 ml serum ➢ Blood: 20-40 ml (cytogenetics) (Na-Heparin) ➢ each of 2 unstained bone marrow and blood smears	➢ Bone marrow: ≥10ml (molecular) (Na- EDTA) ➢ Blood: 20-40 ml (molecular) (Na-EDTA)	➢ Bone marrow: ≥10ml (molecular) (Na- EDTA) ➢ Blood: 20-40 ml (molecular) (Na-EDTA) In case of relapse: ➢ Bone marrow: ≥10ml (cytogenetics) (Na-Heparin) ➢ Blood: 20-40 ml (cytogenetics) (Na-Heparin)
	*Please note: If your site is activated for and the patient is eligible for one of the following trials: AMLSG 30-18, AMLSG 31-19, AMLSG 34-23 or AMLSG 35-24, please send ≥10ml bone marrow for flow cytometry (LAIP) to the central lab in Ulm		
Date of Sampling:			
Blood Count: **Please fill out!!!**	_____ G/l Leucocytes _____ G/l Thrombocytes	_____% Lymphocytes _____mg/dl Hemoglobin	_____% Blasts (mandatory) _____% Neutrophiles

Site: ..... Requesting Physician: ..... Tel: ..... Fax: ..... **Date:** **Signature:**	**Comment:**