THE UNIVERSITY OF TEXAS MD Anderson Cancer Center

COMPREHENSIVE REGISTRATION/ADMISSION FORM

UNIVERSITY OF TEXAS REGENERA ADVANCED CELL THERAPEUTICS & RESEARCH CENTER STEM CELL REGENERATIVE PROGRAMS, PRECISION IMMUNOTHERAPIES, MOLECULAR & CELLULAR DISEASE MANAGEMENT

SECTION 1: PATIENT DEMOGRAPHICS

Full Legal Name: [Prefix] ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other: _____
First: _____ Middle: _____ Last: _____

Date of Birth: DD / MM / YYYY

Gender Identity: ☐ Male ☐ Female ☐ Non-Binary ☐ Prefer not to say ☐ Other: _____

National ID/Passport: _____ Number: _____
Issuing Country: _____

Ethnicity _____ (For genetic disorder profiling)

Immunization Records

- Last Tetanus Shot: /___ ☐ Up to date ☐ Not up to date
- COVID-19 Vaccination: ☐ Yes (Doses: ___) ☐ No
- Other Vaccines: _____

FAMILY MEDICAL HISTORY

- ☐ Hypertension ☐ Diabetes ☐ Heart Disease ☐ Cancer ☐ Stroke ☐ Genetic Disorders
- Specify relation (e.g., father, sister): _____

SECTION 2: CONTACT & EMERGENCY INFORMATION

Primary Address | Street: _____
City: _____ State/Province: _____ ZIP: _____ Country: _____
Contact | Phone: _____ Alternate Phone: _____ Email: _____
Emergency Contact (1) |Name: _____ Relationship: _____ Phone: _____
Emergency Contact (2) |Name: _____ Relationship: _____ Phone: _____

SECTION 3: PRE-TREATMENT WORKUP

Laboratory Tests Conducted:
• Complete Blood Count: _____ Renal Function: _____ Liver Enzymes: _____
• Tumor Markers (if cancer): _____ Viral Serology: _____
• Genetic Testing (if applicable): _____

Imaging:
☐ MRI ☐ CT ☐ PET Scan ☐ Echocardiogram ☐ Bone Scan
Findings: _____
Biopsy/Pathology Report (if cancer):
• Tumor Grade: _____ Genetic Mutations (e.g., BRCA, KRAS): _____
Vital Signs:
• Blood Pressure: _____ Heart Rate: _____ Peripheral Oxygen Saturation: _____
Temperature: _____ Body Weight: _____

SECTION 4: PRIMARY DIAGNOSIS & SPECIALIZATION AREA

(Check all applicable specialties & specify conditions)

Disease Category / Specific Condition(s)

☐ 1. Cancer
Breast / Prostate / Lung / Colorectal / Skin / Bladder / Non-Hodgkin Lymphoma / Kidney / Pancreatic / Leukemias / Thyroid / Liver / Gynecologic (Specify: _____)

☐ 2. Neuro Disorders
Stroke (☐ Ischemic ☐ Hemorrhagic ☐ TIA) / Alzheimer's / Parkinson's / ALS / Huntington's / Frontotemporal Dementia / MS / Guillain-Barré / Epilepsy / ASD / ADHD

☐ 3. Cardiovascular
HFrEF / HFpEF / PAD / Cardiomyopathy (☐ Dilated ☐ Hypertrophic ☐ Arrhythmogenic) / Atherosclerosis / Arrhythmia (☐ Atrial Fibrillation ☐ Ventricular Tachycardia)

☐ 4. Autoimmune
Lupus (SLE) / RA / Sjögren's / Type 1 Diabetes / Hashimoto's / Myasthenia Gravis / Crohn's / Ulcerative Colitis / Psoriasis

---

☐ 5. Genetic/Cell Disorders

Gaucher / Niemann-Pick / Fabry / Glycogen Storage / Mitochondrial (☐ MELAS ☐ Leigh ☐ Kearns-Sayre) / Sickle Cell / Thalassemia / Aplastic Anemia / Duchenne MD / Cystic Fibrosis / Marfan / Ehlers-Danlos

---

☐ 6. Immunodeficiencies

SCID / CVID / DiGeorge / HIV/AIDS / Chemotherapy-Induced

☐ 7. Organ Damage/Failure

Cirrhosis / Hepatitis (☐ B ☐ C) / Alcoholic Liver / CKD / Glomerulonephritis / Polycystic Kidney / Pulmonary Fibrosis (☐ Idiopathic ☐ Silicosis)

☐ 8. Musculoskeletal

Osteoarthritis / Osteoporosis / Non-Healing Fracture / Osteogenesis Imperfecta / Rhabdomyolysis

---

☐ 9. Skin/Wound Disorders

Diabetic Ulcer / Venous Stasis Ulcer / Severe Burns / Keloids / Hypertrophic Scars / Epidermolysis Bullosa / Pemphigus

---

☐ 10. Eye Disorders

Macular Degeneration (☐ Dry ☐ Wet) / Keratoconus / Corneal Dystrophy / Glaucoma / Retinitis Pigmentosa

---

☐ 11. Aging-Related

Frailty Syndrome / Osteoporosis / Sarcopenia / Cognitive Decline

---

Date of Initial Diagnosis: _____

Referred By: ☐ Physician (Name: _____) ☐ Self ☐ Other: _____

THE UNIVERSITY OF TEXAS MD Anderson Cancer Center COMPREHENSIVE REGISTRATION/ADMISSION FORM

SECTION 5: MEDICAL HISTORY & CURRENT TREATMENTS

List of Current Medications (Name, Dose, Frequency):

1) _____
2) _____
3) _____
4) _____
5) _____

Allergies | Drug/Food/Other: _____ Reaction: _____
Past Surgeries | Procedure: _____ Date: _____Hospital: _____
Previous Therapies| Chemo/Radiation/Stem Cell/Immunotherapy/Other: _____
Genetic Testing Done? | ☐ Yes (Upload report) ☐ No ☐ Pending

SECTION 6: STEM CELL THERAPY ELIGIBILITY CRITERIA

Condition-Specific Protocol (Match to primary diagnosis):

☐ CAR-T Cell Therapy (Leukemia, Lymphoma)
☐ Cardiac Progenitor Cells (Heart Failure)
☐ Mesenchymal Stem Cells (Osteoarthritis, Bone Fractures)
☐ Hematopoietic Stem Cell Transplant (MS, Sickle Cell Anemia)
☐ Retinal Stem Cells (Macular Degeneration)
☐ Neural Stem Cells (Stroke, Alzheimer's/Parkinson's)
☐ Gene-Edited Stem Cells (Cystic Fibrosis, Duchenne MD)
☐ Autologous Skin Grafts (Burns/Chronic Wounds)
☐ Other: _____

ELIGIBILITY SCREENING

☐ Confirmed diagnosis via biopsy/imaging/lab results (Attach reports).
☐ Failed standard therapies (e.g., chemotherapy, immunosuppressants).
☐ Adequate organ function (e.g., LVEF >40% for cardiac therapy).
☐ No active infections or untreated malignancies (exceptions: cancer patients).
☐ Patient consents to experimental/off-label use.

SECTION 7: ADVANCED THERAPY INTEREST & CONSENT

(Select therapies of interest)

Research-Based Programs consent for Data Use

Search based programes	Consent data use
stem cell regenerative programe	☐ consent to my anonymized data being used for research
BiTEs / Trispecific Antibodies	☐ consent to biopsy/genetic material storage (5 years)
TCR-T Cell Therapy	
Cancer-Killing Bacteria	Treatment Risks Acknowledgement
Sonodynamic Therapy (SDT)	I understand these therapies are innovative and may involve unknown risks
Ferroptosis Inducers	
Photothermal/Photodynamic (PTT/PDT)	
mRNA Cancer Vaccines	Signature: _____ Date: _____
Exosome-Based Therapies	
Epigenetic Editing	
AI-Designed Drug Combinations	

SECTION 8: LIFESTYLE & SUPPORT SYSTEM

Tobacco/Alcohol Use | ☐ Never ☐ Former ☐ Current (Frequency: _____)
Diet/Exercise | ☐ Sedentary ☐ Light Activity ☐ Moderate ☐ Intensive
Living Situation | ☐ Alone ☐ With Family ☐ Assisted Facility
Primary Caregiver | Name: _____ Contact: _____ Relationship: _____

THE UNIVERSITY OF TEXAS MD Anderson Cancer Center COMPREHENSIVE REGISTRATION/ADMISSION FORM

SECTION 9: INSURANCE, REGISTRATION FEE & FINANCIAL RESPONSIBILITY

Primary Insurance Provider: _____ Policy #: _____
Group #: _____ Expiry: DD / MM / YYYY
Secondary Insurance Provider: _____ Policy#: _____
Financial Guarantor | Name: _____Relationship: _____Contact: _____

1. **Registration Fee**
Amount: $412 (Non-refundable)
Purpose: Covers administrative processing, initial specialist consultation, and medical candidacy assessment.
Final amount confirmed during consultation scheduling. Price locked for 72h after invoice.

2. **Payment Method**
(✓ Select one option)
[ ] Credit/Debit Card
Cardholder Name: _____
Card Number: Expiry: ___/___ | CVV: ___

[ ] Bank Transfer
Account details provided upon submission

[ ] Financing Plan
Selected plan: _____ (Coordinator will contact you)

3. **Fee Coverage Details**
This fee includes:
- [x] Medical history review & digital records processing
- [x] 45-min initial specialist consultation
- [x] Treatment candidacy assessment
- [ ] Diagnostics/imaging (billed separately)

4. **Financial Policies**
☐ I understand:
- Registration fee non-refundable if canceled <72h prior
- Fee applicable toward treatment costs within 90 days
- No insurance coverage per FDA/EMA experimental status

5. **Discounts & Assistance**
- [ ] Research participation discount (IRB study ID: _____)
- [ ] Sliding-scale fee consideration (Attach income proof)
- [ ] Military/VA benefits inquiry

6. **Refund Protocol**
- Refunds processed in USD within 5 business days
- Historical rate documentation provided

SECTION 10: PATIENT DECLARATION

I certify that all information provided is accurate. I authorize MD Anderson to share medical data with specialists involved in my care. I understand that falsification may impact treatment outcomes.

Patient Signature: _____ Date: _____
Witness (Staff): _____ ID Badge #: _____

Administrative Use Only
Admitting Physician: Dr. _____ Dept: _____
Patient ID: REG-_____-202_
Priority Status| ☐ Urgent (24h) ☐ High (72h) ☐ Standard (1-2 weeks)
Initial Assessment Notes
_____
_____
_____
_____
_____
_____