Český národní registr dárců dřeně

CZECH NATIONAL MARROW DONORS REGISTRY

Czech Republic, 323 00 Plzeň, Alej Svobody 80
Fax: +420 373 034 442, Phone: +420 373 034 333, E-mail: registr@kostnidren.cz

FORMAL REQUEST FOR HUMAN STEM CELL COLLECTION

PATIENT DATA

Patient name:			Patient ID: (assigned by patient's registry)	
Patient registry:			Patient ID: (assigned by donor's registry)	
Transplant center:				
Diagnosis:			Current disease status:	
Date of birth: (YYYY-MM-DD)	Gender:	Weight: kg	CMV:	Blood group/RhD:

DONOR DATA

Donor ID:		Donor GRID:		
Date of birth: (YYYY-MM-DD)	Gender:	Weight: kg	CMV:	Blood group/RhD:
Donor registry:				

TRANSPLANT CENTER

Institution:	
Shipping address:	Invoice address:
Contact person:	Contact person:
Phone:	Phone:
Fax:	Fax:
E-mail:	E-mail:

PRODUCT REQUEST

Product preference: **Human Bone Marrow** (HPC, Marrow) **Stimulated Human PBSC** (HPC, Apheresis)

1 = 1st preference; 2 = 2nd preference; 0 = not desired if 1st preference not possible

Reason for product preference:

WMDA

Reset Form

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Patient registry:	Patient ID: (assigned by donor's registry)
Transplant center:	
Donor ID:	Donor GRID:
Donor registry:	

DONOR PREFERENCE

Are any other donors under consideration for donation on behalf of this patient?	☐ Yes ☐ No
Are any other donors in process of physical examination on behalf of this patient	☐ Yes ☐ No
If you have answered yes to either of these questions above, is this donor requested for stem cell collection on this form the preferred donor?	☐ Yes ☐ No
If no, please explain:	

PROTOCOL DATA (A *brief* protocol flow chart must be enclosed)

Products that are *included* in the protocol and therefore may later be requested:

☐ If >1 DLI, please specify number: ☐ Additional BM ☐ Additional PBSC

☐ Other, please specify:

Total number of days of conditioning regimen:

Number of days of chemotherapy the patient will receive prior to infusion:

Number of days of radiation the patient will receive prior to infusion:

TRANSPLANT HISTORY

Has this patient received any previous stem cell transplants? ☐ Yes ☐ No

If yes, specify source of stem cells: ☐ Autologous ☐ Related donor ☐ Unrelated donor ☐ Cord blood

PREFERRED DATES (in order of preference)

Collection date (YYYY-MM-DD)	Corresponding infusion date (YYYY-MM-DD)
1	**1**
2	**2**
3	**3**
Minimum number of days prior to collection that donor clearance must be received:	

REQUIRED DOCUMENTATION TO ACCOMPANY THIS REQUEST

1. Final compatibility test results form/copy of laboratory HLA typing results of patient and donor
2. Completed marrow and/or PBSC prescription form(s)

Person completing form:	Date (YYYY-MM-DD):	Signature:

WMDA

Reset Form