

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 PERIPHERAL **BLOOD LYMPHOCYTE COLLECTION (TC, Apheresis)**

PATIENT DATA		Page	1 of 2			
Patient name:			Patient ID):		
			(assigned by	у ра	atient registry)	
Patient registry:		Patient ID:				
			(assigned by donor registry)			
Transplant center:						
Diagnosis:			Current d	ise	ase status:	
Date of birth: (YYYY-MM-DD)	Gender:	Weig	ht: ł	٢g	CMV:	Blood group/RhD:
DONOR DATA						
Donor ID: Donor GRID:						
Date of birth: (YYYY-MM-DD)	Gender:	Weig	ht: ł	٢g	CMV:	Blood group/RhD:
Donor registry:						

TRANSPLANT CENTER DATA

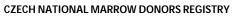
nstitution:		
Shipping address:	Invoice address:	
Contact person:	Contact person:	
Phone:	Phone:	
Fax:	Fax:	
E-mail:	E-mail:	

PRODUCT REQUEST

DLI: If >3rd DLI, indicate no. of DLI	
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PROTOCOL DATA Please enclose a brief protocol flow chart		
Products that are <i>included</i> in the protocol and therefore may later be requested:		
If >1 DLI, please specify number:	nal PBSC	
Other, please specify:		
List types and dates of any previous (allogenic) transplants:		
Did the donor being requested above previously donate stem cells on behalf of this patient? Yes No		
Was any of the original stem cell product cryopreserved for later infusion?		
If yes, was that product infused?	□Yes □No	







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

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 clo	earance must be received:

REQUIRED DOCUMENTATION TO ACCOMPANY THIS REQUEST

- 1. Detailed description of patient's post-transplantation condition
- 2. Summary of transplant protocol to be used with the most recent protocol review date
- 3. Completed prescription of peripheral blood lymphocyte collection form
- 4. WMDA form previous transplant history or equivalent

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

