

## DONOR FINAL CLEARANCE PRE-STEM CELL COLLECTION

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PATIENT DATA	
Patient name:	Patient ID: (assigned by patient registry)
Patient registry:	Patient ID: (assigned by donor registry)
Transplant center:	

DONOR DATA			
Donor ID:	Donor GRID:		
Donor registry:			
Date of birth: (YYYY-MM-DD)	Gender:	Weight in kg:	Blood group/RhD:
Transfusions:	Number:	Pregnancies:	Number:

TEST DATA				
Test:	positive	negative:	not tested:	Date tested: (YYYY-MM-DD)
<b>Hepatitis B Virus (HBV)</b>				
HBs Ag (surface antigen screening test)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anti-HBc (antibody screening test)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HBV-NAT (Nucleic Acid Amplification Technique)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Hepatitis C Virus (HCV)</b>				
Anti-HCV (antibody screening test)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HCV (RIBA verification test)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HCV-NAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Human T-Lymphotropic Viruses (HTLV)</b>				
Anti-HTLV I/II (screening test)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Human Immunodeficiency Virus (HIV)</b>				
HIV 1 p24 antigen (screening test)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HIV-NAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anti-HIV 1 and Anti-HIV 2 (antibody screening test)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Syphilis</b>				
STS (serological test for syphilis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Other</b>				
CMV (Cytomegalovirus) antibodies	IgG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	IgM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	total	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WNV-NAT testing (West Nile Virus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
EBV (Epstein Barr Virus) antibodies	IgM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	IgG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toxoplasmosis antibodies	IgG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	IgM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	total	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	normal:	elevated:	not tested:	
ALT (Alanine Aminotransferase)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other(s), please specify:				

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

VERIFICATION TEST DATA				
Test:	positive	negative:	not tested:	Date tested: (YYYY-MM-DD)
HBs Ag neutralization (surface antigen verification test)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anti-HTLV I/II (verification test. 2nd test performed with a different kit)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HIV 1 p24 antigen neutralization (verification test)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anti-HIV 1 by Western Blot (verification test)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anti-HIV 2 by Immunoblot (verification test)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FTA-ABS (verification test)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other(s), please specify:				

Informed consent signed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date (YYYY-MM-DD):
Collection date(s) (YYYY-MM-DD):	Start date G-CSF:
Medical clearance provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date (YYYY-MM-DD):
If final clearance for donation is not granted, please detail reason(s):	
Additional comments:	
Collection method preferred by donor: <input type="checkbox"/> bone marrow <input type="checkbox"/> peripheral blood stem cells	

Donor/collection center representative:	Date (YYYY-MM-DD):	Donor/collection center signature:
Reviewer checking this form:	Date (YYYY-MM-DD):	Reviewer signature:

TRANSPLANT CENTER ACCEPTANCE OF DONOR FINAL CLEARANCE		
I have received and reviewed the pre-collection physical examination test results and/or summaries from the lead collection physician for this donor.		
<input type="checkbox"/> I find that this volunteer stem cell donor is an acceptable donor for stem cell collection scheduled to occur on the dates listed above. Patient consent for the donation has been verified.		
<input type="checkbox"/> I do not require further testing or information at this time.		
<input type="checkbox"/> Based on the results provided, additional testing must be performed or additional information provided before stem cell collection can occur. Please provide additional comments below.		
Comments:		
Transplant center representative:	Date (YYYY-MM-DD):	Transplant center signature: