PREVIOUS TRANSPLANT HISTORY

PATIENT DATA				
Patient name:			Patient ID: (assigned by patient registry)	
Patient registry:				
Transplant center:			Patient ID: (assigned by donor registry)	
Pre-transplant diagnosis:			Disease status at time of initial transplant:	
Date of Birth: (YYYY-MM-DD)	Gender:	Weight (kg): Image Field	CMV:	Blood group/RhD:
Current disease status:				
Reason for subsequent donation request:				

DONOR DATA Information on currently requested donor	
Donor registry:	Donor ID:
Donor GRID:	

DATA FROM PREVIOUS TRANSPLANT			
Number of previous infusions:		Date of last stem cell infusion (YYYY-MM-DD):	
Manipulation:		Other:	
Source of stem cells for last infusion:	☐ Allogeneic marrow ☐ Autologous	☐ Allogeneic PBSC ☐ Related	☐ Cord Blood ☐ Unrelated
Cell dose administered to recipient:	**Marrow:** x 10^8/kg (MNC)	**PBSC:** x 10^6/kg (CD34+)	
Details on conditioning treatment:	☐ Myeloablative	☐ Non-myeloablative	
Did the conditioning regimen include TBI?	☐ Yes	☐ No	
GvHD prophylaxis administered:	☐ Yes	☐ No	If yes, state name of agent:
Was any portion of the stem cell product cryopreserved?	☐ Yes	☐ No	Reason for cryopreservation:
If Yes, list the cell dose available:	**Marrow:** x 10^8/kg (MNC)	**PBSC:** x 10^6/kg (CD34+)	
If any portion of the stem cell product was cryopreserved, was it infused?	☐ Yes	☐ No	
If Yes, what was the date of infusion? (YYYY-MM-DD)	Reason for infusion:		
Are autologous rescue cells available?	☐ Yes	☐ No	
Alternative treatment for patient besides URD:			
Is there an alternative suitable unrelated donor?	☐ Yes	☐ No	
Is there an alternative suitable unrelated cord blood unit?	☐ Yes	☐ No	

ENGRAFTMENT DATA/DISEASE STATUS					
Engraftment:	☐ Yes	☐ No	Date neutrophils > 0.5 x 10^9/L (YYYY-MM-DD):		
Chimerism results:	☐ Donor	☐ Mixed	☐ Recipient	☐ Not performed	Date (YYYY-MM-DD):
If mixed please state percentage: donor	%, recipient	%			
Best response of disease to transplant:					Date achieved: (YYYY-MM-DD)

TRANSPLANT RELATED COMPLICATIONS IN PATIENT						
GVHD: (grade/organs involved and treatment received)	Acute:		Grade:		Resolved:	
	Chronic:		Grade:		Resolved:	
Did the patient suffer from any serious infections?	☐ Yes	☐ No	If yes, please specify:			
Resolved:	☐ Yes	☐ No	Additional information:			
Did the patient suffer of organ toxicity?	☐ Yes	☐ No	If yes, please specify:			
Resolved:	☐ Yes	☐ No				

WMDA

Reset Form

PREVIOUS TRANSPLANT HISTORY

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

CURRENT CLINICAL STATUS OF PATIENT

The clinical condition of the patient is: ☐ Excellent ☐ Good ☐ Deteriorated

Is the patient in need of any intensive medical support? ☐ Yes ☐ No

If yes, please check all that apply: ☐ Ventilator ☐ Dialysis ☐ Other:

Is the patient receiving any of the following medication? Please check all that apply:

☐ Hematopoietic growth factors ☐ Immunosuppressive ☐ Antibiotics ☐ Other:

CURRENT PATIENT CONDITION (Laboratory data)

Hemoglobin: ☐ Is the patient red cell transfusion dependent? ☐ Yes ☐ No

If yes, date last transfusion (YYYY-MM-DD):

Platelets: x 10^9/L | Is the patient platelet transfusion dependent? ☐ Yes ☐ No

If yes, date last transfusion (YYYY-MM-DD):

Is the patient suffering from liver function abnormalities? ☐ Yes ☐ No

If yes, please add relevant laboratory findings:

Is the patient suffering from kidney function abnormalities? ☐ Yes ☐ No

If yes, please add relevant laboratory findings:

PREVIOUS REQUESTS FOR SUBSEQUENT DONATION

Has there been a previous post transplant donation request for this donor? ☐ Yes ☐ No

What product was requested? ☐ Bone marrow ☐ PBSC ☐ Donor Lymphocytes

Was the request approved? ☐ Yes ☐ No

If the request was refused, please state why:

DETAILS PLANNED ON NEW SCT

Will the patient receive further conditioning prior to infusion? ☐ Yes ☐ No

☐ Myeloablative ☐ Non-myeloablative | Will the conditioning regimen include TBI? ☐ Yes ☐ No

Is product manipulation planned? ☐ Yes ☐ No | If yes, please specify: ☐

Will prophylaxis for GVHD be given? ☐ Yes ☐ No

Please state the expected response probability for your patient and describe the evidence for your expectation:

PRODUCT PREFERENCE

☐ Reason for product preference:

This form is required for any formal request for subsequent donation.

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

Reset Form