

## PREVIOUS TRANSPLANT HISTORY

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

DONOR DATA Information on currently requested donor	
Donor registry:	ION:
Donor ID:	
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:			
Cell dose administered to recipient:	Marrow: $x 10^8/\text{kg}$ (MNC)	PBSC:	$x 10^6/\text{kg}$ (CD34+)
Details on conditioning treatment:	<input type="radio"/> Myeloablative <input type="radio"/> Non-myeloablative		
Did the conditioning regimen include TBI?	<input type="radio"/> Yes <input type="radio"/> No		
GvHD prophylaxis administered:	<input type="radio"/> Yes <input type="radio"/> No	If yes, state name of agent:	
Was any portion of the stem cell product cryopreserved?	<input type="radio"/> Yes <input type="radio"/> No	Reason for cryopreservation:	
If Yes, list the cell dose available:	Marrow: $x 10^8/\text{kg}$ (MNC)	PBSC:	$x 10^6/\text{kg}$ (CD34+)
If any portion of the stem cell product was cryopreserved, was it infused? <input type="radio"/> Yes <input type="radio"/> No			
If Yes, what was the date of infusion? (YYYY-MM-DD)		Reason for infusion:	
Are autologous rescue cells available? <input type="radio"/> Yes <input type="radio"/> No			
<i>Alternative treatment for patient besides URD:</i>			
Is there an alternative suitable unrelated donor? <input type="radio"/> Yes <input type="radio"/> No			
Is there an alternative suitable unrelated cord blood unit? <input type="radio"/> Yes <input type="radio"/> No			

ENGRAFTMENT DATA/DISEASE STATUS			
Engraftment: <input type="radio"/> Yes <input type="radio"/> No	Date neutrophils $> 0.5 \times 10^9/\text{L}$ : (YYYY-MM-DD)		
Chimerism results: <input type="radio"/> Donor <input type="radio"/> Mixed <input type="radio"/> Recipient <input type="radio"/> Not performed	Date: (YYYY-MM-DD)		
If mixed, please state percentage:	% donor and	% recipient	
Best response of disease to transplant:			Date achieved: (YYYY-MM-DD)

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

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

CURRENT CLINICAL STATUS OF PATIENT			
The clinical condition of the patient is: <input type="radio"/> Excellent <input type="radio"/> Good <input type="radio"/> Deteriorated			
Is the patient in need of any intensive medical support? <input type="radio"/> Yes <input type="radio"/> No			
If yes, please check all that apply: <input type="checkbox"/> Ventilator <input type="checkbox"/> Dialysis <input type="checkbox"/> Other:			
Is the patient receiving any of the following medication? Please check all that apply:			
<input type="checkbox"/> Hematopoietic growth factors <input type="checkbox"/> Immunosuppressive <input type="checkbox"/> Antibiotics <input type="checkbox"/> Other:			

CURRENT PATIENT CONDITION (Laboratory data)	
Hemoglobin:	Is the patient red cell transfusion dependent? <input type="radio"/> Yes <input type="radio"/> No
If yes, date last transfusion: (YYYY-MM-DD)	
Platelets: $\times 10^9/L$	Is the patient platelet transfusion dependent? <input type="radio"/> Yes <input type="radio"/> No
If yes, date last transfusion: (YYYY-MM-DD)	
Leukocyte count: $\times 10^9/L$	Test date: (YYYY-MM-DD)
Is the patient suffering from liver function abnormalities? <input type="radio"/> Yes <input type="radio"/> No	
If yes, please add relevant laboratory findings:	
Is the patient suffering from kidney function abnormalities? <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No	
What product was requested? <input type="radio"/> Bone marrow <input type="radio"/> PBSC <input type="radio"/> Donor Lymphocytes	
Was the request approved? <input type="radio"/> Yes <input type="radio"/> No	
If the request was refused, please state why:	

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

DETAILS PLANNED ON NEW SCT	
Will the patient receive further conditioning prior to infusion? <input type="radio"/> Yes <input type="radio"/> No	
<input type="radio"/> Myeloablative <input type="radio"/> Non-myeloablative	Will the conditioning regimen include TBI? <input type="radio"/> Yes <input type="radio"/> No
Is product manipulation planned? <input type="radio"/> Yes <input type="radio"/> No	If yes, please specify:
Will prophylaxis for GvHD be given? <input type="radio"/> Yes <input type="radio"/> 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 form:	Date: (YYYY-MM-DD)	Signature: