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 AND PRESCRIPTION FOR HPC,MARROW; HPC, APHERESIS AND/OR MNC, APHERESIS

PATIENT DATA				
Patient name:				
Patient registry:				
Diagnosis:				
Patient ID: (assigned by patient registry)		Patient ID: (assigned by donor registry)		
Transplant centre:				
Date of birth: (YYYY-MM-DD)	Gender:	Weight: (kg)	CMV:	Blood group/RhD:

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

Product shipping address:	**Invoice(s)** to be sent to: Copy shipping address
Institution:	Institution:
Address:	Address:
ZIP code:	ZIP code:
City:	City:
Country:	Country:
Attention:	Attention:
Phone:	Phone:
Fax:	Fax:
E-mail:	E-mail:

PRODUCT REQUEST

- ◯ HPC, Marrow ONLY
- ◯ HPC, Apheresis ONLY
- ◯ MNC, Apheresis, please specify number of DLI (e.g. 1st, 2nd):
- ◯ HPC, Marrow, second option: HPC, Apheresis
- ◯ HPC, Apheresis, second option: HPC, Marrow

Reason for product preference:

DONOR PREFERENCE (in case of HPC, Marrow and/or HPC, Apheresis)		
Are any other donors under consideration for donation of 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:		

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

DONOR DATA	
Donor registry:	ION:
Donor ID:	
GRID:	

PROTOCOL DATA please enclose a brief protocol flow chart if applicable

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

☐ Additional HPC, Marrow ☐ Additional HPC, Apheresis ☐ MNC, Apheresis, please specify number of DLI:

☐ Other, please specify:

Total days of conditioning regimen the patient will receive prior to infusion:

This includes chemotherapy for days, and radiation for days

TRANSPLANT HISTORY

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

If yes, please include WMDA Form F20 and answer following transplant history questions.

List types and dates of previous (allogenic) transplants:

Specify source of stem cells :

Reason for subsequent transplant:

In case the current request is for a MNC apheresis answer the following transplant history questions:

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? ◯Yes ◯No

If yes, was that product infused? ◯Yes ◯No

PREFERRED DATES (in order of preference)	
(First) 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:	

PICK UP PREFERENCE

Pick up preference, if one apheresis is sufficient:

◯Pick up at the end of the first collection day

◯No pick up preference

Comments:

PRE-COLLECTION SAMPLES

Are pre-collection samples required? ◯Yes ◯No

Sample type: ml heparin ml EDTA ml ACD

ml no anticoagulant ml other:

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

DONOR DATA	
Donor registry:	ION:
Donor ID:	
GRID:	

PRE-COLLECTION SAMPLES TO BE SHIPPED TO:	
Institution:	
Attention:	
Address:	
ZIP code:	
City:	Country:
Phone:	Fax:
Email:	

STEM CELL AND/OR LYMPHOCYTE COLLECTION		
Product type:		
Cell type:		
Required cells/kg		
x Patient weight (kg)		
= Total number of cells		
+ Cells for quality assurance testing		
= Total number of cells		
Please provide explanation for high number of cells:	Please provide explanation for high number of cells:	
IRB/Ethics board approval (or equivalent): Date: (YYYY-MM-DD)	IRB/Ethics board approval (or equivalent): Date: (YYYY-MM-DD)	

ADDITIONAL SAMPLES TO ACCOMPANY STEM CELL OR LYMPHOCYTE PRODUCT
Peripheral blood samples:
ml heparin ml ACD ml EDTA ml no anticoagulant
ml product tube, type: ml other:
Samples to be taken on collection day:
Additional comments:

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

DONOR DATA	
Donor registry:	ION:
Donor ID:	
GRID:	

TRANSPORT DATA	
Product type:	Product type:
Required anticoagulant:	Required anticoagulant:
☐ Heparin ☐ EDTA ☐ ACD ☐ Other:	☐ Heparin ☐ EDTA ☐ ACD ☐ Other:
Donor plasma required? ◯ Yes ◯ No	Donor plasma required? ◯ Yes ◯ No
If yes, please indicate the desired final concentration:	If yes, please indicate the desired final concentration:
Transport temperature:	Transport temperature:
Preferred method of overnight storage of product(s) (if needed):	Preferred method of overnight storage of product(s) (if needed):
Additional instructions:	Additional instructions:

REQUIRED DOCUMENTATION TO ACCOMPANY THIS REQUEST

In case of HPC, Marrow and/or HPC, Apheresis:

1. WMDA Form F30 Final Compatibility Test Results, or equivalent

In case of MNC, Apheresis:

1. Summary of transplant protocol to be used with the most recent protocol review date
2. WMDA Form F20 Transplant History, or equivalent

DISCLAIMER:

- The cell products collected from this donor are intended solely for the purpose of immediate therapeutic treatment for the above mentioned patient.Any planned cryopreservation of the cell products prior to initial infusion to the patient may only occur with the advance written approval from the donor centre .
- Excess cells may be stored for future therapeutic treatment for this patient. No other uses of these cells are permissible. Cells not used for the therapeutic treatment of the above mentioned patient must be disposed of properly and details must be provided to the donor centre.
- The donor centre must be provided detailed information concerning the use and/or disposal of all portions of this cell product. By accepting these cells, the transplant physician also accepts these terms and conditions. Deviations from these terms are not permitted without prior written approval from the donor centre.
- Any serious product events and/or adverse reactions must be reported both to the donor's registry and transplant center. Corresponding S(P)EAR reports must be completed by the registry providing the product, submitted to the WMDA office and details must provided to the donor centre.

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

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