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

# PREVIOUS TRANSPLANT HISTORY



| **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/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<br>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:*<br>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 and | | % recipient | | |
| Best response of disease to transplant: | | | | | Date achieved: (YYYY-MM-DD) |

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| **PATIENT DATA** | |
|---|---|
| Patient first name: | Patient last name: |
| Patient registry: | |
| Transplant centre: | |
| Patient ID: (assigned by patient registry) | Patient ID: (assigned by donor registry) |

| **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: 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

**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)

Leukocyte count: x 10^9/L Test date: (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:

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| **PATIENT DATA** | |
|---|---|
| Patient first name: | Patient last name: |
| Patient registry: | |
| Transplant centre: | |
| Patient ID:<br>(assigned by patient registry) | Patient ID:<br>(assigned by donor registry) |

| **DONOR DATA** Information on currently requested donor | |
|---|---|
| Donor registry: | ION: |
| Donor ID: | |
| GRID: | |

| **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** | |
|---|---|
| choose 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: |

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