

## COLLECTION REPORT

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<input type="radio"/> HPC, Marrow	<input type="radio"/> HPC, Apheresis	<input type="radio"/> MNC, Apheresis
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PATIENT DATA	
Patient first name:	Patient last name:
Patient registry:	
Transplant center:	
Patient ID: <small>(assigned by patient registry)</small>	Patient ID: <small>(assigned by donor registry)</small>

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

Collection centre	Transplant centre
Institution:	Institution:
Address:	Address:
ZIP code:	ZIP code:
City:	City:
Country:	Country:
Attention:	Attention:
Phone:	Phone:
Fax:	Fax:
E-mail:	E-mail:

PRODUCT DATA				
				Totals:
Collected volume in ml:				
Anticoagulant volume in ml:				
Donor plasma volume in ml:				
Other additives, please specify:				
Product ID				
Totals in ml:				
Total number of (nucleated) cells in 10 <sup>8</sup> :				
Hematocrit in %:				

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PATIENT DATA	
Patient first name:	Patient last name:
Patient registry:	
Transplant center:	
Patient ID: <small>(assigned by patient registry)</small>	Patient ID: <small>(assigned by donor registry)</small>

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

PRODUCT DATA <i>(continued)</i>			
Blood cell separator model & software version:	Overnight storage:	Temperature stored:	Number of hours:
	Bag 1 <input type="checkbox"/> Yes <input type="checkbox"/> No		
Amount of whole blood processed in ml:	Bag 2 <input type="checkbox"/> Yes <input type="checkbox"/> No		
Was this product filtered? <input type="checkbox"/> Yes <input type="checkbox"/> No	Bag 3 <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is CD34 enumeration performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Bag 4 <input type="checkbox"/> Yes <input type="checkbox"/> No		
Transport temperature:	Additional comments:		

STEM CELL COLLECTION DATA		
	Collection day 1	Collection day 2 (if applicable)
Date of stem cell collection: (YYYY-MM-DD)		
Time started: (HH:MM + local time zone)		
Time completed: (HH:MM + local time zone)		
Tissue culture media used:		
Anticoagulant used:		

ADDITIONAL SAMPLES TO ACCOMPANY STEM CELL PRODUCT			
Sample type:	ml heparin	ml EDTA	ml ACD
Samples taken on apheresis day:	ml no anticoagulant	ml other:	

**DISCLAIMER:**

Human blood cells for transplantation. Handle with care! Do not irradiate! Deliver immediately!

- 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 centre. Corresponding SEAR/SPEAR reports must be completed by the registry providing the product, submitted to the WMDA office and details must be provided to the donor centre.

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