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

DONOR FINAL CLEARANCE PRE-STEM CELL COLLECTION

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

DONOR DATA			
Donor ID:		Donor GRID:	
Donor registry:			
Date of birth: (YYYY-MM-DD)	Gender:	Weight in kg:	Blood group/RhD:
Transfusions:	Number:	Pregnancies:	Number:

TEST DATA					
Test:		positive	negative:	not tested:	Date tested: (YYYY-MM-DD)
Hepatitis B Virus (HBV)					
HBs Ag (surface antigen screening test)		☐	☐	☐	
Anti-HBc (antibody screening test)		☐	☐	☐	
HBV-NAT (Nucleic Acid Amplification Technique)		☐	☐	☐	
Hepatitis C Virus (HCV)					
Anti-HCV (antibody screening test)		☐	☐	☐	
HCV (RIBA verification test)		☐	☐	☐	
HCV-NAT		☐	☐	☐	
Human T-Lymphotropic Viruses (HTLV)					
Anti-HTLV I/II (screening test)		☐	☐	☐	
Human Immunodeficiency Virus (HIV)					
HIV 1 p24 antigen (screening test)		☐	☐	☐	
HIV-NAT		☐	☐	☐	
Anti-HIV 1 and Anti-HIV 2 (antibody screening test)		☐	☐	☐	
Syphilis					
STS (serological test for syphilis)		☐	☐	☐	
Other					
CMV (Cytomegalovirus) antibodies	IgG	☐	☐	☐	
	IgM	☐	☐	☐	
	total	☐	☐	☐	
WNV-NAT testing (West Nile Virus)		☐	☐	☐	
EBV (Epstein Barr Virus) antibodies	IgM	☐	☐	☐	
	IgG	☐	☐	☐	
Toxoplasmosis antibodies	IgG	☐	☐	☐	
	IgM	☐	☐	☐	
	total	☐	☐	☐	
		normal:	elevated:	not tested:	
ALT (Alanine Aminotransferase)		☐	☐	☐	
Other(s), please specify:					

Reset Form

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Patient name:	Patient ID: (assigned by patient registry)
Patient registry:	
Transplant center:	Patient ID: (assigned by donor registry)
Donor ID:	Donor GRID:
Donor registry:	

VERIFICATION TEST DATA

Test:	positive	negative:	not tested:	Date tested: (YYYY-MM-DD)
HBs Ag neutralization (surface antigen verification test)	☐	☐	☐	
Anti-HTLV I/II (verification test. 2nd test performed with a different kit)	☐	☐	☐	
HIV 1 p24 antigen neutralization (verification test)	☐	☐	☐	
Anti-HIV 1 by Western Blot (verification test)	☐	☐	☐	
Anti-HIV 2 by Immunoblot (verification test)	☐	☐	☐	
FTA-ABS (verification test)	☐	☐	☐	

Other(s), please specify:

Informed consent signed? ☐ Yes ☐ No	Date (YYYY-MM-DD):
Collection date(s) (YYYY-MM-DD):	Start date G-CSF:
Medical clearance provided? ☐ Yes ☐ No	Date (YYYY-MM-DD):
If final clearance for donation is not granted, please detail reason(s):	
Additional comments:	
Collection method preferred by donor: ☐ bone marrow ☐ peripheral blood stem cells	

Donor/collection center representative:	Date (YYYY-MM-DD):	Donor/collection center signature:
Reviewer checking this form:	Date (YYYY-MM-DD):	Reviewer signature:

TRANSPLANT CENTER ACCEPTANCE OF DONOR FINAL CLEARANCE

I have received and reviewed the pre-collection physical examination test results and/or summaries from the lead collection physician for this donor.

☐ I find that this volunteer stem cell donor is an acceptable donor for stem cell collection scheduled to occur on the dates listed above. Patient consent for the donation has been verified.

☐ I do not require further testing or information at this time.

☐ Based on the results provided, additional testing must be performed or additional information provided before stem cell collection can occur. Please provide additional comments below.

Comments:

Transplant center representative:	Date (YYYY-MM-DD):	Transplant center signature:

WMDA

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