CENTRUM ORGANIZACYJNO-KOORDYNACYJNE ds. TRANSPLANTACJI
Centralny Rejestr Potencjalnych Niespokrewnionych Dawców Szpiku i Krwi Pępowinowej POLTRANSPLANT
02-001 Warszawa, Al. Jerozolimskie 87

Warszawa, 22 czerwca 2017 r.

Tel/fax (+48-22) 627 07 48 e-mail: rejestr@szpik.info

FORMAL REQUEST for SUBSEQUENT DONATION and PREVIOUS TRANSPLANT HISTORY

(To be submitted with formal request for subsequent stem cell collections)

PATIENT DATA:

Patient Name:			Date of Birth: (yyyy-mm-dd)
Patient ID: (assigned by patient's registry)	Patient ID: (assigned by donor's registry)		Patient Registry:
Gender:	CMV:	AB0/Rh:	Weight: (kg)
Transplant Centre Address:		Contact name:	
		Phone:	
		Fax:	
		E-mail:	

DONOR DATA: Information on currently requested donor

Donor ID:			Date of Birth: (yyyy-mm-dd)	
Donor Registry:	Gender:	CMV:	AB0/Rh:	Weight: (kg)

DATA FROM PREVIOUS TRANSPLANT:

Pre-transplant diagnosis:	Disease status at time of initial transplant:	
Current disease status:	Number of allogeneic transplants: ___Related ___ Unrelated	
Reason for subsequent donation request:		
Was there any SPEAR involved? ____Yes ____No If yes, please send SPEAR report		
Date of previous stem cell infusion (yyyy-mm-dd):	Manipulation: (state type e.g. T-cell depletion, plasma removal etc)	
Source of stem cells for last transplant: ______Bone Marrow _____PBSC ____Cord Blood		
Cell dose administered to recipient:	Marrow ____x 10^8 / kg (MNC)	PBSC _____x 10^6 / kg (CD34+)
Details on conditioning treatment:	_______Myeloablative _________Dose-reduced Did the conditioning regimen include TBI? ___-Yes ____No	
GvHD prophylaxis administered:		

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Patient ID: (assigned by patient's registry)	Donor ID:

DATA FROM PREVIOUS TRANSPLANT (continued):

Was any portion of the stem cell product frozen?	____Yes ____No Reason for freezing:	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 frozen, was it infused?	____Yes _____No If Yes, what was the date of infusion? Reason for infusion: (yyyy-mm-dd)	
Is autologous back up marrow/PBSC available?	____Yes ______No Collection date (yyyy-mm-dd):	

ENGRAFTMENT DATA / DISEASE STATUS

Engraftment: _______Yes ______--No Date (neutrophils > 0.5 x 10^9/L) (yyyy-mm-dd)	
In case of allogeneic HPC transplant hematopoietic chimerism (most recent result with date): ____Donor ____Mixed ____Recipient ____Not performed Date (yyyy-mm-dd): Please state percentage: donor ______% recipient _____% Best response of disease to transplant: Date achieved (yyyy-mm-dd): Evaluated by:	
Current disease status: Most recent data on disease / chimerism: Molecular disease status: Chimerism:	Date of assessment (yyyy-mm-dd) Date of result (yyyy-mm-dd): Date of result (yyyy-mm-dd):
Evaluated by:	

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Patient ID(assigned by patient's registry):	Donor ID:

TRANSPLANT RELATED COMPLICATIONS IN PATIENT:

GVHD: (Grade/organs involved and treatment received) Acute -______Yes ____No Grade_____ Resolved ____-Yes _____No Chronic _____Yes ____No Grade_____ Resolved _____Yes ____No
Serious infection: (State type and treatment received) Resolved: ______Yes _______No
Organ toxicity/Other: Describe type and treatment: Resolved: ____Yes ____No

CURRENT CLINICAL STATUS OF PATIENT:

Physical examination: (state significant findings) Karnofsky / Lansky: Current medication: Describe any intensive medical support the recipient is receiving e.g. Ventilation, dialysis etc:

CURRENT RECIPIENT CONDITION (Laboratory Data):
(Blanks are considered to represent normal results)

WBC: WBC Differential	Neutrophils	Blasts
	Lymphocytes	Others
Hemoglobin: _________ g/dL Frequency of red blood cell transfusions: Date of last red cell transfusion (yyyy-mm-dd):		
Platelets: x 10^9/L Frequency of platelet transfusions: Date of last platelet transfusion (yyyy-mm-dd):		
Please give the following results only if abnormal:		

Urea: ___________mg/dL	AST: __________U/L
Creatinine:__________ mg/dL	Alkaline Phosphatase: __________U/L
Bilirubin: __________-mg/dL	Chest X-Ray: ____Yes _____No

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Patient ID: (assigned by patient's registry)	Donor ID:

PREVIOUS REQUESTS FOR SUBSEQUENT DONATION:

Has there been a previous post transplant donation request for this donor? _____Yes _____No
If yes, was the request approved? _____Yes _____No
If the request was refused, state why:

Product requested:

PRODUCT REQUEST:

Product preference: __ Bone Marrow (BM) __ PBSC __ Unit of whole blood __ T-cells	Please fill in a numeric value next to products to indicate preference: 1=1st preference; 2=2nd preference; 0=not desired if 1st preference not possible
Reason for product preference: (Please provide relevant information)	

DETAILS ON PLANNED NEW HPC TRANSPLANT:

Planned recipient treatment: (with dates)

Is recipient conditioning planned? _____Yes _____No
If yes, number of days of conditioning prior to HPC infusion: __________

Preferred first collection date (yyyy-mm-dd):_______________

Alternative dates (yyyy-mm-dd): ___________________
Minimum number of days prior to collection that donor clearance must be received: ____________

Is product manipulation planned? _______Yes ________No

If yes, briefly describe the planned manipulation:

Prophylaxis for GVHD:

Treatment alternative for patient besides URD

Is a backup marrow/PBSC or frozen marrow/PBSC available? ____Yes ____No

Is there an alternative suitable unrelated donor? ____Yes ____No

Is there an alternative suitable unrelated cord blood unit? ____Yes____ No
Please state the expected response probability for your patient and describe the evidence for your expectation:

REQUIRED DOCUMENTATION TO ACCOMPANY THIS REQUEST

Completed Marrow, PBSC or T-cell Prescription Form(s)
A prescription form is not required for a unit of blood.

Person Completing Form:	Signature:	Date: (yyyy-mm-dd)