DONOR WORKUP REQUEST AND PRESCRIPTION FORM

Instructions:

- All fields are mandatory. Indicate N/A where necessary, do not leave any fields blank.
- As this is a fillable PDF, please complete the form electronically. If handwritten forms are submitted, please write legibly.
- Include the following documents with this request.
  - Donor and Patient Laboratory HLA Typing.
  - BMDP F-07 Transplant History Form – For subsequent donations and MNCs requests.

PATIENT DATA				
BMDP Patient ID		Ethnicity:		
Patient Registry ID				
Patient Registry/ Transplant Centre				
Patient Diagnosis				
Age:	Gender:	Weight:	CMV:	Blood Group/RHD:

DONOR DATA				
GRID no	3 7 8 5 - _ _ _ _ - _ _ _ _ - _ _ _ _ _ _ _ _			
Donor ID				
Age:	Gender:	Weight:	CMV:	Blood Group/RHD:

PRE-COLLECTION SAMPLE- WORKUP STAGE (Note: 50 ml is the maximum volume that can be requested)		
i. Are pre-collection samples required?	☐ Yes ☐ No	
ii. Shipping conditions	☐ Cooled 2 - 8 °C *(Additional charges may apply)* ☐ Uncontrolled Ambient *(Room Temperature)*	
No anticoagulant (ml)	**ACD (ml)**	**EDTA (ml)**
Additional Remarks (Please indicate if there is any extra testing required at workup in this section)		
iii. Pre-collection sample shipping information		
Attention/Name		
Institution		
Address Line 1		
Address Line 2		
Telephone #		
Email Address		

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Donor ID		Patient ID	
GRID no.	3 7 8 5 - _ _ _ _ - _ _ _ _ - _ _ _ _ - _ _ _		

DONOR PREFERENCE	
01. Are there other donors under consideration for this patient?	☐ Yes ☐ No
02. Are there other donors in process of physical examination for this patient?	☐ Yes ☐ No
03. If you have answered yes to any of the above, is the BMDP donor referenced above the preferred donor? If no, please explain below:	☐ Yes ☐ No

TRANSPLANT HISTORY	
01. Has this patient received any previous stem cell transplant?	☐ Yes ☐ No
These questions shall only be answered in case of subsequent donation and please submit BMDP F-07 Transplant History form to accompany this request:	
02. Please list the source, types, and dates of any previous (allogeneic) transplants:	
03. Has the donor referenced above donated the stem cells to this patient before?	☐ Yes ☐ No
03a. If yes, was any of the original stem cell product cryopreserved for later infusion?	☐ Yes ☐ No ☐ N/A
03b. If yes, was that product infused? Please also indicate the date of infusion: _______________ (DD/MMM/YYYY)	☐ Yes ☐ No ☐ N/A

PREFERRED DATES / PROTOCOL DATA			
Preferred Collection Dates (in order of preference – DD/MMM/YYYY)		**Corresponding Planned Infusion Dates (DD/MMM/YYYY)**	
01.		**01.**	
02.		**02.**	
03.		**03.**	
Min. number of days prior to collection that donor clearance must be received			
Total number of days of conditioning regimen			

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Bone Marrow Donor Programme 8 Sinaran Drive, #03-02 Novena Specialist Center, Singapore 307470 T: +65 69160370 F: +65 69160371

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STEM CELL CHOICE			
Choice	**PBSC**	**Bone Marrow**	**Lymphocyte**
1st	☐	☐	☐
2nd	☐	☐	☐

COLLECTION DETAILS			
Product Type	**HPC, Apheresis** (limit 2-5 x 10^6 $CD34^+$/kg)	**HPC, Marrow** (limit 2 x 10^8 TNC/kg)	**Lymphocyte**
Cell Type	**CD34+**	**TNC**	**CD3+**
Required Cells/kg			
Patient Weight (kg)			
Total number of cells (required cells x patient weight)			
Cells for quality assurance testing			
Transport Temperature (°C)			
Additional instructions (if any)			

PBSC Collection *(Medical explanation for requesting more than 5 X 10^6 CD34+/kg patient weight)*
(BMDP USE ONLY) Medical Doctor on Call Comments:
Marrow Collection *(Medical explanation for requesting more than 2 X 10^8 TNC/kg patient weight)*
(BMDP USE ONLY) Medical Doctor on Call Comments:

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DAY OF COLLECTION (Note: 50ml is the maximum volume that can be requested)	
i. Are additional samples required?	☐ Yes ☐ No
ii. Is Donor plasma required?	☐ Yes ☐ No
If yes, please indicate final concentration of plasma: **(Note: max of 100ml plasma per donation day can be requested. 200ml per day for cryopreserved product)**	

Indicate the amount and type of tube(s) required by the Transplant Centre:

	Peripheral Blood		Product	
	Day 1 (marrow and PBSC)	**Day 2** (PBSC)	**Day 1** (marrow and PBSC)	**Day 2** (PBSC)
No anticoagulant (ml)				
ACD (ml)				
EDTA (ml)				
Additional blood samples shipping temperature	☐ Cooled 2 - 8 °C *(Additional charges may apply)* ☐ Uncontrolled Ambient *(Room Temperature)*			

Additional Remarks

PRODUCT TRANSPORT / DELIVERY INFORMATION

Attention/Name:			
Contact Number:			
Fax Number:			
Email:			
Facility:			
Address:			
Country:		**Postal/Zip Code:**	
Emergency contact and number: **(Name and person must be different from the main contact above)**			

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DISCLAIMER:

- The BMDP ***will not*** initiate a second day collection if the number of cells collected on day one has reached 3 x 10^6/kg patient weight unless an amount greater than 5 x 10^6/kg patient weight is requested and approved by BMDP medical subcommittee
- The cell products collected from the donor are intended solely for the purpose of immediate therapeutic treatment of the above-mentioned patient unless planned cryopreservation prior to initial infusion to the patient is approved in advance by BMDP's medical chairperson.
- For cryopreservation request that is approved by BMDP's medical chairperson, BMDP shall initiate a second day collection if the number of cells collected on day one is less than 5 x 10^6 CD34+ cells/kg patient weight unless an amount less than 5 x 10^6 CD34+ cells/kg patient weight is requested.
- Items that were loaned from CC for cryopreservation such as cassettes and cryobox must be returned within a month after donation date or additional charges may be imposed.
- Excess cells may be stored for future therapeutic treatment of the 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 according to internal procedures and details provided to BMDP.
- BMDP must be provided detailed information concerning the use and/or disposal of all portions of this cell product. Deviations from these terms are not permitted without written prior approval from BMDP.
- Any serious product events and/or adverse reactions must be reported to the BMDP within 24 hours of occurrence and thereafter a SEAR/SPEAR report must be completed and submitted to the WMDA office by the BMDP.

Regarding the donor designated above, I verify that the relevant information is acceptable to proceed with stem cell collection for above patient.

Form Completed By	**Date (DD/MMM/YYYY)**	**Transplant Physician Signature**

FOR OFFICIAL USE ONLY

BMDP Medical Panel Doctor-on-call's signature is required for approvals of any request for cell dose exceeding the above-mentioned limits.

Name of Doctor-on-call	**Date (DD/MMM/YYYY)**	**Doctor-on-call Signature**

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