RESET PRINT

Donor Workup Request

Patient ID: _____ TC Code: _____

GRID: _____ Registry Donor ID: _____

1. Patient Information

Current diagnosis: _____

If AML, ALL, or other acute leukemia, indicate current disease status **and** number of remissions:

○ Primary induction failure ○ Complete remission ○ Relapse ○ Induction therapy in progress

If CML, indicate the current status of the leukemia (check one):

○ Chronic phase ○ Accelerated phase ○ Blastic phase

If Severe Aplastic Anemia, has patient been transfused?

○ Yes ○ No

Has the patient previously received an allogeneic cellular therapy (related or unrelated)?

○ Yes ○ No

If the patient previously received an allogeneic cellular therapy, ensure buccal swabs are used for patient initial and confirmatory typing.

2. Stem Cell Choice

First Choice: ○ HPC, Apheresis ○ HPC, Marrow

Second Choice: ○ None ○ HPC, Apheresis ○ HPC, Marrow

Be sure to fill out the prescription for the second-choice product.

3. Pre-Collection Samples

Do you require pre-collection samples to be drawn? ○ Yes ○ No

Will CT be performed on the pre-collection samples? ○ Yes ○ No

Do you require pre-collection samples **be sent to a second location**? ○ Yes ○ No

Do not include samples related to a transplant center research study that requires NMDP IRB approval. Instead, complete the *Request for NMDP Donor to Participate in a Research Study* form.

Pre-Collection blood samples: **50 ml** is the maximum volume that can be requested for U.S. donors. **35 ml** is the maximum volume that can be requested for non-U.S. donors.

First Set of Blood Samples

Yellow Top (ACD)	Purple Top (EDTA)	Green Top (Heparin)	Red Top (No Anticoagulant)
_____ x _____ ml	_____ x _____ ml	_____ x _____ ml	_____ x _____ ml

Total ml Requested:

If requesting over 50 ml (U.S.) or 35 ml (non-U.S.), please provide rational for request:

Pre-Collection Sample Shipping Information

Center Name: _____

Attn / Name: _____

Address Line 1: _____

Address Line 2: _____

Address Line 3: _____

City, State, Province, Region: _____

Zip Code, Postal Code, Country: _____

Telephone: _____

Email Address: _____

Donor Workup Request

Patient ID: _____ TC Code: _____

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3. Pre-Collection Samples (continued)

Please only fill out the tube quantity, type, and shipping information if a second set of samples is being requested to be sent to a different location.

Pre-Collection blood samples: **50 ml** is the maximum volume that can be requested for U.S. donors. **35 ml** is the maximum volume that can be requested for non-U.S. donors.

Second Set of Blood Samples

Yellow Top (ACD)	Purple Top (EDTA)	Green Top (Heparin)	Red Top (No Anticoagulant)
_____ x _____ ml	_____ x _____ ml	_____ x _____ ml	_____ x _____ ml

Total ml Requested (second set of samples):

If requesting over 50 ml (U.S.) or 35 ml (non-U.S.), please provide rational for request:

Second Set - Pre-Collection Sample Shipping Information

Center Name: _____

Attn / Name: _____

Address Line 1: _____

Address Line 2: _____

Address Line 3: _____

City, State, Province, Region: _____

Zip Code, Postal Code, Country: _____

Telephone: _____

Email Address: _____

Samples will be drawn with the required PE samples. If that is not acceptable, please specify when samples should be drawn:

Additional Comments:

Donor Workup Request

Patient ID: _____ TC Code: _____

GRID: _____ Registry Donor ID: _____

4. HPC, Marrow Collection

Prescription:

Nucleated cells per kg (uncorrected):		_____	x 10^8/kg
Patient weight:	x	_____	kg
Total nucleated cells for patient:	=	_____	x 10^8
Nucleated cells for quality assurance:	+	_____	x 10^8
Total nucleated cells requested:	=	_____	x 10^8

When requesting a cell dose of 6 or greater, please provide a rationale for the request:

Cryopreservation:

Cryopreservation planned: ○ No ○ Yes (select location): ○ TC ○ AC/CC ○ NMDP

NOTE: For product cryopreservation at a location other than the TC, day of collection samples will be shipped directly to the TC. If the TC is not able to receive samples separately from the product, the samples will ship at the same temperature as the product inside the dry shipper container.

Anticoagulants:

NOTE: Heparin is always added to the product to prevent coagulation during transport.

Do you require additional anticoagulants be added to the marrow during or after aspiration?

○ No ○ Yes ○ ACD-A ○ Other: _____ Ratio: _____

Special Processing Requests:

Additional Comments:

Transport and Storage Conditions:

○ Room Temperature ○ Cooled (1-10 degree C)

Desired Clearance and Collection Timeline:

Enter your preferred proposed collection and corresponding donor clearance dates:

	Proposed Collection Date (mm/dd/yy)	**Clearance needed by** (mm/dd/yy)
First Choice - Required		

Specify the length of the patient's prep regimen in days: _____

If proposing additional options, specify the number of days clearance is needed prior to the collection date: _____

While the donor center will always attempt to meet the preferred date, please select one or more of the options below:

☐ Donor center to provide earliest next available date

☐ Attempt to schedule on certain days of the week: ☐S ☐M ☐Tu ☐W ☐T ☐F ☐Sa

Donor Workup Request

Patient ID: _____ TC Code: _____

GRID: _____ Registry Donor ID: _____

5. HPC, Apheresis Collection

Prescription:

CD34+ cells per kg:		_____ x 10^6/kg
Patient weight:	x	_____ kg
Total CD34+ cells for patient:	=	_____ x 10^6
CD34+ cells for quality assurance:	+	_____ x 10^6
Total CD34+ cells requested:	=	_____ x 10^6

When requesting a cell dose of 6 or greater, please provide a rationale for the request:

When CD34+ counts are not available, the Apheresis Center collects based on patient weight as outlined below:

- Patient weight ≤ 35kg — One 12-liter Apheresis procedure performed.
- Patient weight 36 – 45kg — One 15-liter Apheresis procedure performed.
- Patient weight 46 – 55kg — One 18-liter **or** two 12-liter Apheresis procedure(s) performed.
- Patient weight 56 – 65kg — One 22-liter **or** two 12-liter Apheresis procedure(s) performed.
- Patient weight > 65kg — One 30-liter **or** two 12-liter Apheresis procedure(s) performed.

Cryopreservation:

Cryopreservation planned: ○ No ○ Yes (select location): ○ TC ○ AC/CC ○ NMDP

NOTE: For product cryopreservation at a location other than the TC, day of collection samples will be shipped directly to the TC. If the TC is not able to receive samples separately from the product, the samples will ship at the same temperature as the product inside the dry shipper container.

Donor Plasma:

Donor plasma requested: ○ No ○ Yes: _____ ml ○ In a separate bag ○ Added to the product

Additives:

Do you require additional additives be added to the product? ○ No ○ Yes

If yes: Additive required: _____ Ratio: _____

Special Processing Requests:

Additional Comments:

Transport and Storage Conditions: Reminder – HPC, Apheresis will be stored and transported cooled.

Desired Clearance and Collection Timeline:

Enter your preferred proposed collection and corresponding donor clearance dates:

	Proposed Collection Date (mm/dd/yy)	**Clearance needed by** (mm/dd/yy)
First Choice - Required		

Specify the length of the patient's prep regimen in days: _____

If proposing additional options, specify the number of days clearance is needed prior to the collection date: _____

Donor Workup Request

Patient ID: _____ TC Code: _____

GRID: _____ Registry Donor ID: _____

5. HPC, Apheresis Collection (continued)

While the donor center will always attempt to meet the preferred date, please select one or more of the options below:

☐ Donor center to provide earliest next available date

☐ Attempt to schedule on certain days of the week: ☐ S ☐ M ☐ Tu ☐ W ☐ T ☐ F ☐ Sa

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6. Day of Collection Samples

A minimum of 10 ml of donor peripheral blood must be drawn with each product collected.

Peripheral Blood				
	Yellow Top (ACD)	Purple Top (EDTA)	Green Top (Heparin)	Red Top (No Anticoagulant)
Day 1	_____ x _____ ml	_____ x _____ ml	_____ x _____ ml	_____ x _____ ml
Day 2	_____ x _____ ml	_____ x _____ ml	_____ x _____ ml	_____ x _____ ml
Product Samples				
	Yellow Top (ACD)	Purple Top (EDTA)	Green Top (Heparin)	Red Top (No Anticoagulant)
Day 1	_____ x _____ ml	_____ x _____ ml	_____ x _____ ml	_____ x _____ ml
Day 2	_____ x _____ ml	_____ x _____ ml	_____ x _____ ml	_____ x _____ ml

Will the day of collection samples be sent with the product? ◯ Yes ◯ No

If no, enter the destination shipping details for the day of collection samples that will not be sent with the product:

Center Name: _____

Attn / Name: _____

Address Line 1: _____

Address Line 2: _____

Address Line 3: _____

City, State, Province, Region: _____

Zip Code, Postal Code, Country: _____

Telephone: _____

Email Address: _____

Donor Workup Request

Patient ID: _____ TC Code: _____

GRID: _____ Registry Donor ID: _____

6. Day of Collection Samples (continued)

Additional Comments:

Do you need a second set of samples sent to a different location? ○ Yes ○ No

If yes, enter the samples needed for the second set:

Peripheral Blood				
	Yellow Top (ACD)	Purple Top (EDTA)	Green Top (Heparin)	Red Top (No Anticoagulant)
Day 1	_____ x _____ ml	_____ x _____ ml	_____ x _____ ml	_____ x _____ ml
Day 2	_____ x _____ ml	_____ x _____ ml	_____ x _____ ml	_____ x _____ ml
Product Samples				
	Yellow Top (ACD)	Purple Top (EDTA)	Green Top (Heparin)	Red Top (No Anticoagulant)
Day 1	_____ x _____ ml	_____ x _____ ml	_____ x _____ ml	_____ x _____ ml
Day 2	_____ x _____ ml	_____ x _____ ml	_____ x _____ ml	_____ x _____ ml

Additional Comments:

Donor Workup Request

Patient ID: _____ TC Code: _____

GRID: _____ Registry Donor ID: _____

6. Day of Collection Samples (continued)

Center Name: _____

Attn / Name: _____

Address Line 1: _____

Address Line 2: _____

Address Line 3: _____

City, State, Province, Region: _____

Zip Code, Postal Code, Country: _____

Telephone: _____

Email Address: _____

NOTE: For product cryopreservation at a location other than the TC, day of collection samples will be shipped directly to the TC. If the TC is not able to receive samples separately from the product, the samples will ship at the same temperature as the product inside the dry shipper container.

7. Additional Product Information

Product Delivery Address

Center/Company Name: _____

Attn / Name: _____

Address Line 1: _____

Address Line 2: _____

Address Line 3: _____

City, State, Province, Region: _____

Zip Code, Postal Code, Country: _____

Telephone: _____

Email Address: _____

1st Emergency Contact Name: _____

1st Emergency Contact Phone: _____

2nd Emergency Contact Name: _____

2nd Emergency Contact Phone: _____

Donor Workup Request

Patient ID: _____ TC Code: _____

GRID: _____ Registry Donor ID: _____

7. Additional Product Information (continued)

Apheresis Center: Fax CD34+ results to the following number: _____

Email Address: _____ Fax Number: _____

After-hours emergency contact number for the NMDP on-call Case Manager: **(763) 406-4400**

Regarding the donor designated above, I verify that the ABO type, degree of HLA match, compatibility testing results and infectious disease results are acceptable to proceed with stem cell collection for above patient.

Form Completed By: _____

Ordering Physician: _____

Form Submission Date: _____

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8. Comments (optional)**:**

The donor center will receive this information.

Do not provide confidential patient information in this section.

Donor Workup Request

Patient ID: _____ TC Code: _____

GRID: _____ Registry Donor ID: _____

9. Outstanding Requests & Additional Information

Should outstanding DR/HR or CT requests be canceled?* ○ Yes ○ No

*It may not be possible to cancel request for typing in progress or for donors with an appointment scheduled in the next 2-3 days. The transplant center is financially responsible for the services that cannot be canceled.

Additional Comments:

Will you be requesting multiple donors for workup? ○ Yes ○ No

Held Donor and Cord Options:

Are there backup donors that should be Held for Workup? ○ Yes ○ No

Backup donor 1: _____

Backup donor 2: _____

Are there backup cord blood units (CBU) to place on hold? ○ Yes ○ No

CBU 1: _____ **CBU 2:** _____

CBU 3: _____ **CBU 4:** _____

Information on this page is for NMDP Case Management use only and is not to be shared with the donor center.