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WMDA	Transplant Center Evaluation Form (any Registry)			
	Document type	Form	WG/Committee	WGQR
	Document reference	Transplant Center Evaluation (any Registry)	Approved by	
	Version	1	Approval date	
	Drafting date	OO=01/10/2018	Status	Draft

Transplant Center Evaluation Form (any Registry)

Please complete this form, which will be used by _____ [*Registry name*] to evaluate your center's hematopoietic stem cell transplant (HSCT) experience.
NOTE: If your center is currently FACT-JACIE accredited for allogeneic transplantation, please e-mail a copy of your FACT-JACIE certificate and the form with the following sections (marked by *) filled:

General Information*
Transplant Center Medical Director*
Primary Contact Person (Coordinator)*
Back-up Coordinator*
Emergency contacts*

Abbreviations used in this form:

HSCT	Hematopoietic Stem Cell Transplant
HPC(A)	Hematopoietic Progenitor Cells, Apheresis [*also known as peripheral blood stem cells or PBSC*]
HPC(CB)	Hematopoietic Progenitor Cells, Cord Blood
HPC(M)	Hematopoietic Progenitor Cells, Marrow
TC	Transplant Center

General Information*		
Legal name of TC:		
If applicable, English name of TC and/or abbreviation:		
Mailing address:		
City:		Postal code:
Country:	Website:	
Transplant Center Medical Director*		
First name:		Degree(s):
Surname:		Title:
Mailing address:		
City:		Postal code:
Country:	E-mail:	
Office phone number:	Mobile number:	Fax number:

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Primary Contact Person (Coordinator)*		
First name:		Degree(s):
Surname:		Title:
Mailing Address:		
City:		Postal code:
Country:	E-mail:	
Office phone number:	Mobile number:	Fax number:
Is Contact Person/Coordinator proficient in English? *Required : Yes* ☐ Yes ☐ No		

Facility Description	
1.	Which year(s) did the HSCT unit at your TC begin performing autologous and allogeneic transplants? Autologous:_____ Allogeneic:_____
2.	Center accepts (check one): ☐ Adult patients only ☐ Pediatric patients only ☐ Adult and pediatric patients
3.	Please indicate the number of beds on the inpatient HSCT unit: Number of adult beds:_____ Number of pediatric beds: _____
4.	Are there defined practices to minimize the risk of airborne contamination in inpatient rooms? Please describe details. *Required: Yes* ☐ Yes ☐ No Details:
5.	Do all patient treatment areas (both inpatient and outpatient/clinic areas) have processes in place to minimize the risk of spreading infection? *Required: Yes* ☐ Yes ☐ No
6.	Please provide copies of any licenses, accreditations, or certificates by your national government (if applicable) and/or other agency relevant to authorizing your center to perform HSCT transplants at your institution. *Required: Yes, if applicable*
	☐ Attached items: ☐ No attachment, please comment:

7. List the number of patients who received transplants in each of the last 2 full calendar years and in the current year to date by stem cell source: *Information only*

YEAR	**Autologous** HPC(M)/HPC(A)	**Related** **(including haploidentical)** HPC(M)/HPC(A)/HPC(CB)	**Unrelated** HPC(M)/HPC(A)/HPC(CB)
Current year to date			

8.		**For adults:**	**For pediatrics:**
	What is the one year overall survival rate for **patients** at your TC after allogeneic transplantation? Please provide separate survival rates for adult versus pediatric patients, if applicable. *Recommended: ≥50% at one year*	1 year:	1 year:
		3 years:	3 years:

Personnel / Transplant Team

9. Identify the transplant physicians involved in the program, the number of years each physician has spent at your program, and their overall experience with allogeneic HSCT. **Please attach the CV of the Transplant Center Medical Director.** If there are more than two physicians in addition to the TC Medical Director, please attach the information in a separate document.

Required: Medical Director must have at least two years of allogeneic HSCT including at least one year of unrelated donor experience and one additional physician must have at least one year of allogeneic HSCT experience

	For adults:	**For pediatrics:**
First name:		
Surname:		
Years of allogeneic HSCT experience:		
Years of unrelated HSCT experience:		
Years at this HSCT program:		
Medical Director?	☐ This is the medical director and CV is enclosed.	☐ This is the medical director and CV is enclosed.

	Additional physician first name:		
	Additional physician surname:		
	Years of allogeneic HSCT experience: *Required: 1 year*		
	Years at this HSCT program:		
	Additional physician first name:		
	Additional physician surname:		
	Years of allogeneic HSCT experience: *Required: 1 year*		
	Years at this HSCT program:		
10.	Is there physician coverage 24 hours per day, seven days per week? *Required: Yes*	☐ Yes ☐ No, please comment:	
11.	HSCT team has nurses with specialized HSCT training and experience: *Required: Yes*	☐ Yes (adults) ☐ Yes (peds) ☐ No, please comment:	

12. Is there a designated, trained backup coordinator and/or other designated personnel proficient in English and available to provide daily and emergency communication? *Required: Yes*

☐ Yes ☐ No, please comment:

Please provide information on the back-up Coordinator(s)*

	Back-up Coordinator
First name:	
Surname:	
E-mail:	
Phone number:	
Job title:	

13. Please list contact information for the registry to reach two emergency contacts, including after-hour phone number(s), mobile phone(s) or a general 24-hour department phone number, as appropriate. Emergency contacts can be any English speaking person on the team, including the medical director or coordinator.*****

	Emergency contact # 1	**Emergency contact # 2**
First name:		
Surname:		
Phone number:		
Mobile number:		
24-hr or HSCT inpatient phone number:		
After hours E-Mail:		

14. Does TC have readily-available internet access for exchange of vital information including search results, transplant logistics, and other essential points of communication? *Required: Yes*

☐ Yes ☐ No (specify alternate means of contact):

Support Services

15. Your TC must have support from an HLA laboratory that will be used for verification typing. Please list the name and location of the HLA laboratory that will be used for intermediate or high-resolution typing, and indicate if the laboratory is accredited for clinical typing by an agency such as the American Society of Histocompatibility and Immunogenetics (ASHI), European Foundation for Immunogenetics (EFI), College of American Pathologists (CAP) or other agency. The laboratory may or may not be affiliated with your transplant hospital.
Required: Accreditation by an established accrediting agency

HLA laboratory name:

☐ Laboratory accreditation certificate attached.

☐ No certificate attached, please explain:

16.	Your TC must have support from a stem cell processing laboratory. Please provide the following information regarding your stem cell processing laboratory:	
	Processing laboratory name:	
	Laboratory capabilities and type of processing performed *Required: Yes to all three capabilities*	a. Count number of nucleated cells and/or quantify CD34+ cells in HPC(A) products received: ☐ Yes ☐ No b. Confirm ABO grouping and Rh typing of HPC(M) or HPC(A) products received: ☐ Yes ☐ No c. Perform fungal and bacterial cultures on products received: ☐ Yes ☐ No

Policies and Administration

17. Please indicate to which outcome registry your TC is reporting your patients' outcome data:

☐ Australian Bone Marrow Transplant Recipient Registry (www.abmtrr.org)
☐ Asia Pacific Blood and Marrow Transplantation Group (www.apbmt.org)
☐ Center for International Blood and Marrow Transplant Research (CIBMTR) (www.cibmtr.org)
☐ European Group for Blood and Marrow Transplantation (EBMT) (www.ebmt.org)
☐ Eastern Mediterranean Blood and Marrow Transplantation Group (www.embmt.org)
☐ Latin America Blood and Marrow Transplantation Group (LABMT)
☐ Other (Specify):

Recommended: Should identify a specific outcome registry.

If your TC is not currently reporting outcome data, what is your plan moving forward?

18. Your TC is required to adhere to applicable WMDA Standards. The WMDA Standards can be found at: https://www.wmda.info/professionals/quality-and-accreditation/wmda-standards/.
Have key transplant center personnel read, understood, and agreed to adhere to the applicable WMDA Standards? *Required: Yes* ☐ Yes ☐ No

19.	Your TC must have defined criteria that outline diagnostic categories for which unrelated HSCT is an acceptable treatment option. Please provide your policy or procedures outlining diagnostic categories for which HSCT is an acceptable treatment. *Required: TC must have defined criteria* ☐ Document attached or describe in comment box. ☐ Other criteria used (e.g. EBMT, BSMT, ASBMT, etc): describe in comment box. ☐ No policy available.	
20.	Your TC must have criteria for an acceptable level of HLA matching between patient and donor for the purpose of unrelated hematopoietic stem cell donation. Please provide documented policy that outlines the acceptable level of matching between patient and donor for acceptable disease indications. *Required: TC must have defined criteria* ☐ Document attached or describe in comment box. ☐ Other published standards used: describe in comment box.	
21.	Does your TC have a policy for reporting serious adverse events? *Required: Yes* ☐ Yes ☐ No	
22.	Does your TC have a policy to protect patient and donor confidentiality? *Required: Yes* ☐ Yes ☐ No	
23.	Does your center have professional and general liability insurance? *Recommended: Should be yes* ☐ Yes ☐ No, please explain:	
24.	Does your transplant center have an informed consent procedure for patients undergoing an international unrelated donor and cord blood unit search? *Required: Yes*	☐ Yes ☐ No Comments:

Declaration	
As the responsible Transplant Center Medical Director, I declare that the information provided on this form is accurate and correct. I will notify_____*[Registry name]* of any significant changes in personnel, facility, accreditation status or support that may have an impact to the activities of the transplant center.	
Date: *(yyyy/mm/dd)*	Signature:

Please submit this form to the registry/ organization that sent you this evaluation form.

Registry/Organization's name: _____

E-Mail: _____