REDOME
INSTITUTO NACIONAL DE CÂNCER

INCA

Donor ID/BR (DMR):	Patient local ID:
GRID:	

PRESCRIPTION FOR STEM CELL COLLECTION

PATIENT / DONOR IDENTIFICATION

Patient initials:

Patient local ID number:
(assigned by patient`s registry)

Donor REDOME ID/BR (DMR):

Patient registry:

PATIENT

Diagnosis:

Current disease status:

Date of birth:
(DD/MM/YYYY)

Gender: ○ M ○ F

Weight in Kg:

Blood group:

CMV: ○ IgM ○ IgG ○ Not tested

TRANSPLANT CENTER

Transplant center name:

Address:

Contact:

Phone:

Fax:

E-mail:

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PRE-COLLECTION ADDITIONAL SAMPLES (maximum 50 mL)
Are pre-collection samples required? ○ Yes ○ No

Sample type: ____ mL heparin ____ mL no anticoagulant ____ mL EDTA ____ mL ACD

____ mL Other:

Samples must be shipped to
Institution:

Phone:

Contact:

Email:

Fax:

Address:

Note: this sample will be shipped at the time of the donor work up unless otherwise requested.

STEM CELL OR LYMPHOCYTE COLLECTION

1st Option
Product type:
○ HPC, Marrow ○ HPC, Apheresis ○ MNC, Apheresis

Cell type: ○ CD34 ○ WBC

Requered cells / Kg: 10^6

Total number of cells: 10^9

Cells for quality assurance testing:

Donor plasma required? ○ Yes ○ No

Required anticoagulant:

Please provide explanation for high number of cells:

2nd Option
Product type:
○ HPC, Marrow ○ HPC, Apheresis ○ MNC, Apheresis

Cell type: ○ CD34 ○ WBC

Requered cells / Kg: 10^6

Total number of cells: 10^9

Cells for quality assurance testing:

Donor plasma required? ○ Yes ○ No

Required anticoagulant:

Please provide explanation for high number of cells:

PREFERED DATES (in order of preferences)

Collection date (DD/MM/YYYY)

1-

2-

3-

Corresponding infusion date (DD/MM/YYYY)

1-

2-

3-

Minimum number of days prior to collection that donor clearance must be received:

Number of days of conditioning prior to transplant:

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TRANSPORT AND STORAGE

Preferred method of overnight storage of products (°C): Transport temperature (°C):

ADDITIONAL SAMPLES TO ACCOMPANY STEM CELL PRODUCT

Are additional peripheral blood samples required? ○ Yes ○ No

Sample type: mL heparin mL no anticoagulant mL EDTA mL ACD

mL Other:

DISCLAIMER:

- The cell products collected from this donor are intended solely for the purpose of immediate therapeutic treatment for above mentioned patient. Any planned cryopreservation of the cell products prior to initial infusion to the patient may only occur with the advance written approval from the donor center.
- Excess cells may be stored for future therapeutic treatment of the above mentioned patient must be disposed of properly and details mus be provided to the donor center.
- The donor center must be provided detailed information concerning to the use and/or disposal of all portions of this cell product. By accepting these cells, the transplant physician also accepts these terms and conditions. Deviations from these terms are not permitted without prior written approval from the donor center.
- Any serious product events and/or adverse reactions mus be reported both to the donor`s registry and transplant center. Corresponding SEAR/SPEAR reports must be completed by registry providing the product, submitted to the WMDA Office and details must provided to the donor center.

Person completing this form:	Date (DD/MM/YYYY):	Signature and stamp:

Please, send this form to the case manager.

Clear Form

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