DONOR WORKUP REQUEST AND PRESCRIPTION FORM

Instructions:

- **All fields are mandatory. Indicate N/A where necessary, do not leave any fields blank.**
- **Please include the following documents with this request:**
  - **Donor's Confirmatory HLA typing report**
  - **Patient's Second HLA verification typing report.**
  - **Patient's HLA antibody report (if donor and patient are mismatched)**

SECTION A: PATIENT INFORMATION				
Patient name:				
Patient registry:	Transplant Centre:		Country:	
HKBMDR Patient ID:		Local Patient ID:		
Age:	Gender: ❑ M ❑ F	Body weight: ____Kg	Blood group/RHD:	CMV:
Diagnosis and disease status:				
Describe current clinical conditions:				
Classify workup based on patient's clinical condition: ❑ Standard ❑ Urgent				
Has the recipient undergone stem cell transplants before? ❑ No ❑ Yes If yes, list the source, type and dates of previous transplants: _____				

SECTION B: DONOR INFORMATION			
1st priority			
GRID	**4 0 7 0** - ____ - ____ - ____ - ____		
HKBMDR Donor **MDID**:			
Age:	Gender: ❑ M ❑ F	Body weight: _____ Kg	Blood group/RHD:
2nd priority			
GRID	**4 0 7 0** - ____ - ____ - ____ - ____		
HKBMDR Donor **MDID**:			
Age:	Gender: ❑ M ❑ F	Body weight:_____ Kg	Blood group/RHD:

SECTION C: CELLULAR THERAPY PRODUCT REQUEST				
1st Choice	❑ PBSC (HPC, Apheresis)	❑ Bone Marrow (HPC, Marrow)	❑ DLI (MNC, Apheresis)	
2nd Choice	❑ PBSC (HPC, Apheresis)	❑ Bone Marrow (HPC, Marrow)	❑ DLI (MNC, Apheresis)	❑ None

SECTION D: PREFERRED DATES / PROTOCOL DATA	
(First) Collection Dates (in order of preference-DD/MM/YYYY)	Corresponding Planned Infusion Dates (DD/MM/YYYY)
1.	1.
2.	2.
3.	3.
Minimum number of days prior to collection that donor clearance must be received: _____ days	
What is recipient's preparative regimen? ❑ Myeloablative ❑ Reduced Intensity	
How many days of preparative regimen are required for recipient? _____days	
List of drugs and/or TBI schedule: _____	

SECTION E: PRE-COLLECTION SAMPLE **AT WORKUP STAGE**		
Are pre-collection samples required at workup stage? ❑ Yes (please specify below) ❑ No *Maximum volume that can be requested: **30ml.** Samples can be shipped in room temperature only.		
EDTA: _____(ml)	ACD-A: _____ (ml)	No anticoagulant:_____ (ml)

Pre-collection Sample Shipping Information			
Attention/ Name			
Institution			
Address Line 1			
Address Line 2			
Country		Postal/Zip Code	
Telephone			
Email address			

HKBMDR PATIENT ID	

SECTION F: PRE-COLLECTION SAMPLE **ON DAY OF COLLECTION**		
Are pre-collection samples required on? ❑ **Yes (please specify below)** ❑ **No**		
	Peripheral Blood (Max **20ml**)	
	Day 1	**Day 2 (PBSC only)**
EDTA (ml)		
ACD-A (ml)		
No anticoagulant (ml)		
Shipping temperature	In room temperature **only**	

SECTION G: PRODUCT TRANSPORT / DELIVERY INFORMATION			
Attention/ Name			
Institution			
Address Line 1			
Address Line 2			
Country		Postal/Zip Code	
Telephone			
Email address			

SECTION H: PBSC (HPC, Apheresis) - COLLECTION DETAILS	
Recipient body weight	**kg**
x Desired CD34+ cells/kg*	**x 10^6/kg**
+ Cells for quality assurance testing	**x 10^6**
= Total number of CD34+ cells	**x 10^6**
Donor's plasma (in separate bag) required (Max 100ml per collection)	❑ Yes, please specify volume required: _____ ml ❑ No
Transport temperature (°C)	
Preferred method of overnight storage of product(s) if needed:	
Additional instructions (if any)	❑ Request for cryopreservation at collection centre ❑ Others:
Remarks: * HKBMDR will aim for a CD34+ cell count of 4 x10^6/kg. If higher cell dose is required, explanation must be provided for HKBMDR physician's approval:	

SECTION I: Bone Marrow (HPC, Marrow) - COLLECTION DETAILS	
Recipient body weight	**kg**
x Desired TNC/kg	**x 10^8/kg**
+ Cells for quality assurance testing	**x 10^8**
= Total number of TNC cells	**x 10^8**
Estimated volume of Bone Marrow required	**ml**
Transport temperature (°C)	
Preferred method of overnight storage of product(s) if needed:	
Additional instructions (if any)	
Remarks: If TNC > 2 x10^8/kg is required, explanation must be provided for HKBMDR physician's approval:	

SECTION J: DLI (MNC, Apheresis) - COLLECTION DETAILS	
Recipient body weight	**kg**
x Desired CD3+ /kg	**x 10^8/kg**
+ Cells for quality assurance testing	**x 10^8**
= Total number of CD3+ cells	**x 10^8**
Transport temperature (°C)	
Preferred method of overnight storage of product(s) if needed:	
Additional instructions (if any)	
Remarks: 2-3 of donor's TBV will be processed in a single apheresis procedure to accommodate request.	

HKBMDR PATIENT ID	

SECTION K: DISCLAIMER

1. **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.**
2. The HKBMDR will aim for a CD34+ cell count of 4 x10^6/kg unless a greater amount is requested and approved by HKBMDR physician.
3. The cell products collected from this donor are intended solely for the purpose of immediate therapeutic treatment for the above-named recipient unless planned cryopreservation prior to initial infusion to the recipient is approved in advance by HKBMDR physician.
4. Excess cells may be stored for future therapeutic treatment for this recipient. No other uses of these cells are permissible. Cells not used for the therapeutic treatment of the above-mentioned recipient must be properly disposed.
5. The HKBMDR must be provided detailed information concerning the use and/or disposal of all portions of this cell product.
6. Any serious product events and/or adverse reactions must be reported to the HKBMDR within 24 hours of occurrence and thereafter a SEAR/SPEAR report must be completed and submitted to the WMDA office by the HKBMDR.
7. By accepting the cell products, the transplant physician also accepts these terms and conditions. Deviations from these terms and conditions are not permitted without written prior approval from HKBMDR.

Form completed by (Name)	**Signature**	**Date (DD/MM/YYYY)**
Transplant Centre Physician (Name)	**Signature**	**Date (DD/MM/YYYY)**

SECTION L: FOR HKBMDR USE ONLY

HKBMDR physician's approval is required for any request for cell dose exceeding the above-mentioned limits.

❑ Approved (on the understanding that if CD34+ cells: **4** x10^6/kg patient weight is reached after day one of collection, the donor will not undergo a second day collection.)

❑ Not approved (follow HKBMDR cell dose limit)

HKBMDR Physician (Name)	**Signature**	**Date (DD/MM/YYYY)**