## FORMAL REQUEST FOR HEMATOPOIETIC PROGENITOR CELL COLLECTION

## PATIENT DATA

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| --- | --- | --- | --- |
| **Patient Last name:** | | **Patient First name:** | **Date of Birth:**  (D/M/Y) |
| **Patient ID:**  (assigned by patient’s registry) | **Patient ID:**  (assigned by donor’s registry) | | **Patient registry:** |

## DONOR DATA

|  |  |  |
| --- | --- | --- |
| **Donor ID:** | **GRID:** | **Donor registry:** |

**TRANSPLANT CENTRE**

|  |  |
| --- | --- |
| Address: | Contact name: |
| Phone: |
| Fax: |
| E-mail: |

**PRODUCT REQUEST**

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| **Product Preference: \_\_\_\_\_\_ Bone Marrow (BM) \_\_\_\_\_\_\_Stimulated PBSC**  Please indicate preference: **1**=1st preference; **2**=2nd preference; **0**=not desired if 1st preference not possible |
| Are any other donors still under consideration for donation on behalf of this patient? Yes No  Are any other donors in the work-up on behalf of this patient? Yes No  If you have answered yes to either of these questions, is this donor requested for stem  cell collection on this form the preferred donor? Yes No |

**PROTOCOL DATA**

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| Products that are *included* in the protocol and therefore may later be requested:  One DLI >1 DLIs (Number:\_\_)  Additional BM  Additional PBSC  Other (Please specify): |

**TRANSPLANT HISTORY**

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| Has this patient received any previous stem cell transplants? YES NO  If YES, specify source of stem cells:  Autologous  Related Donor  Allogeneic Donor  Cord Blood |

**PREFERRED DATES** (in order of preference)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| For marrow harvest, list preferred harvest date. For PBSC collection, please list your preference for the **first** day's collection: | | | | |
| **Collection day:** (D/M/Y) | | Corresponding Infusion Date: | | **Conditioning regimen**  Standard  Reduced/Minimal |
| 1 |  | 1 |  |
| 2 |  | 2 |  |
| 3 |  | 3 |  |
| **Minimum number of days prior to collection that donor clearance must be received: \_\_\_\_\_\_\_\_** Number of days of conditioning prior to transplant: \_\_\_\_\_\_\_\_ Conditioning of patient must not be undertaken until the registry has confirmed the donor to be medically fit and the results of all screening tests are known and have been reported to, and accepted by, the transplant center. | | | | |

**REQUIRED DOCUMENTATION TO ACCOMPANY THIS REQUEST**

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| F048b; F048c; F048d |

|  |  |  |
| --- | --- | --- |
| **Person Completing Form:** | **Signature:** | **Date:**  (D/M/Y) |