



MASTER REQUEST FORM

REQUESTING INSTITUTION	REGISTRY: _____ COUNTRY: _____
	Coordinator: _____ Tel: _____ Fax: _____

REQUESTING TRANSPLANT CENTRE	Name: _____ Contact person: _____
	Address: _____
	City: _____ Tel: _____ Fax: _____

PATIENT DATA

Last name: _____ First name: _____
 Patient ID: _____
 DOB: ____/____/____ CMV: _____ Weight: _____ kgs ABO Rh: _____ Sex: _____
 Diagnosis: _____ Current phase: _____ Diagnosis date: ____/____/____

PATIENT HLA TYPING	A	B	C	DRB1	DQB1	Match <input type="checkbox"/> 6/6 <input type="checkbox"/> 5/6 <input type="checkbox"/> 4/6
	A	B	C	DRB1	DQB1	
CBU HLA TYPING	A	B	C	DRB1	DQB1	
	A	B	C	DRB1	DQB1	

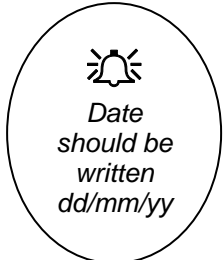
CBU ID: _____

STEPS

Request Date

1 Initial search Repeat search Unit report _____/_____/_____
 ↓
 2 Cord blood HLA high resolution typing request: (also sent via EMDIS yes no)
 A B C DRB1 DQB1 _____/_____/_____
 (at this stage, unit reserved for a period of 2 months)
 ↓
 3 Unit released, reason : _____ _____/_____/_____
 OR
 Unit formally recruited _____/_____/_____
 ↙ ↘
 4 Unit shipment request _____/_____/_____
 Conditioning: _____ days standard reduced
 shipment conditioning infusion
 1 1 1
 2 2 2
 shipping address: Contact person: _____
 address of the _____
 Cell Therapy _____
 Laboratory Tel: _____ Fax _____
 ↓
 5 DNA specimen request (minimum quantity _____) OPTIONAL _____/_____/_____
 shipping address: contact person : _____

 Tel: _____ Fax: _____
 ↓
 6 SPECIFY: - Number of units to be infused: _____
 - Patient included in a protocol YES NO
 if YES, name of protocol: _____
 ↓
 7 Cancellation of search, reason: _____/_____/_____
 Transplant physician's name (block letters): _____ Signature: _____



Use this form chronologically to submit your request to France Greffe de Moelle Registry, Please fax: +33-1-49 98 37 14 or email: coordination.fgm@biomedecine.f

