FRENCH CORD BLOOD REGISTRY

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
	A	B	C	DRB1	DQB1
CBU HLA TYPING	A	B	C	DRB1	DQB1
	A	B	C	DRB1	DQB1

Match
☐ 6/6
☐ 5/6
☐ 4/6

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	

Date should be written dd/mm/yy

***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