agence de la biomédecine

INFECTIOUS DISEASE MARKERS RESULTS

(tests performed prior to blood sample shipment)

PATIENT	Last name: _____ *(3 first letters)* First name: _____ *(3 first letters)* Patient ID: _____ Patient Registry: _____ Country : _____
DONOR	Code: _____ GRID: _____ Donor Registry: _____ Age: _____ Sex: ☐ Male ☐ Female Weight (kg): _____ ABO Rh: _____ and erythrocytic phenotype: _____ Transfusions: ☐ no ☐ yes number: ____ Pregnancies: ☐ no ☐ yes number: ____ ☐ NA CMV status (if known) : _____ date : ___ / ___ / ___ (dd/mm/yy)

INFECTIOUS DISEASE MARKERS	**RESULTS**	**DATE OF TESTING:** ____ / ____ / ____ (dd/mm/yy)
Syphilis	☐ POSITIVE	☐ NEGATIVE
HBs ANTIGEN	☐ POSITIVE	☐ NEGATIVE
ANTI HCV	☐ POSITIVE	☐ NEGATIVE
ANTI HIV1.V2	☐ POSITIVE	☐ NEGATIVE
ANTI HTLV1.V2	☐ POSITIVE	☐ NEGATIVE
CMV *(if unknown or negative)*	☐ POSITIVE	☐ NEGATIVE

Other markers (if any) and/or comments: _____

_____

VERIFICATION OF DONOR'S FITNESS FOR STEM CELL DONATION: ____ / ____ / ____ (dd/mm/yy)

FOR INFORMATION ONLY

Marrow collection day(s) at this centre is/are:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Today's date: ___/___ /___ (dd/mm/yy)

Name of laboratory performing the tests: _____

Name :_____
(person completing the form)

Signature : _____

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