

Patient Data

Patient Name	Patient ID number <small>(assigned by patient's registry)</small>
Patient Registry	Patient ID number <small>(assigned by donor's registry)</small>
Diagnosis	Current disease status

Transplant Center

Hospital	Contact name
Address	Fax nº
	Phone nº
	e-mail

Product Request

Product Preference ___ **Bone Marrow (BM)** ___ **Stimulated PBSC**
Please fill in a numeric value next to both products to indicate preference:
1 = 1st pref.; 2 = nd pref.; 0 = not desired if 1st preference not possible

___ **Donor Lymphocytes**
For Donor Lymphocyte Infusion (DLI)

Protocol Data (A brief protocol flow chart may be enclosed)

1st transplant 2nd transplant > 2nd transplant

If > 2nd transplant, list types and dates of previous transplants

Products that are included in the protocol and therefore may later be Request

One DLI > 1 DLIs (Number: ___) Additional BM

Additional PBSC Platelets Other (Please specify)

DLI: 1st 2nd 3rd <3rd

If > 3rd DLI, indicate nº of DLI:

Preferred Dates (in order of preference)

For PBSC/Lymphocyte collection, please list your preference for the first day's collection

Collection Date	Corresponding transfusion Date
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 should 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 the transplant center)

Required Documentation to Accompany this Request

1. Completed Patient and Donor Details form (form CED 06/04)		
2. Completed Marrow and/or PBSC Prescription forms		
Person Completing the Form	Signature	Date