Gift of Life BONE MARROW FOUNDATION
www.giftoflife.org | 800-9MARROW

headquarters
800 Yamato Road, Suite 101
Boca Raton, Florida 33431 USA

telephone
561.982.2900

coordinating center fax
561.982.2901

donor services fax
561.982.2902

Previous Transplant History and Formal Request for Subsequent Stem Cell Collection

Recipient Data				
Recipient Name:		Recipient ID Number: *(assigned by recipient's registry)*		
Recipient Registry:		Recipient ID Number: *(assigned by donor's registry)*		
Pre-transplant diagnosis:		Disease status at time of initial transplant:		
Date of Birth: ___ / ___ / _____ (Day/Month/Year)	Gender:	Weight (kg):	CMV:	Blood Group / Rh:
Current disease status:				
Reason for subsequent donation request:				

Donor Data				
Donor ID Number:		Donor's Registry:		
Age or Date of Birth: (day/month/year)	Gender:	Weight: (kg)	CMV:	Blood Group / Rh:

Data From Previous Transplant	
Number of previous transplants:	Manipulation: (State type ex. T-Cell depletion, plasma removal, etc.)
Date of last stem cell infusion: ____ / ____ / _____ (Day/Month/Year)	

Source of stem cells for last transplant:

☐ HPC, Marrow ☐ HPC, Apheresis ☐ MNC, Apheresis ☐ Cord Blood

☐ Autologous ☐ Related ☐ Unrelated

In case of unrelated:

Donor ID: _____

Source of stem cells: _____

Date of donation: _____

Cell dose administered to Recipient:	Marrow: _____ x 10^8 / kg (MNC)	PBSC: _____ x 10^6 / kg (CD34+)

Details on conditioning treatment: ☐ Myeloablative

☐ Dose-reduced

Did the conditioning regimen include TBI? ☐ Yes ☐ No

GvHD prophylaxis administered:

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Data From Previous Transplant (Continued)	
Was any portion of the stem cell product frozen?	☐ Yes ☐ No If Yes, reason for freezing: _____
Cell dose available: Marrow: _____ x 10^8 / kg (MNC)	PBSC: _____ x 10^6 / kg (CD34+)
If any portion of the stem cell product was frozen, was it infused?	☐ Yes ☐ No If Yes, what was the date of infusion? Reason for infusion:_____
Is autologous back up marrow/PBSC available?	☐ Yes ☐ No Collection date: ____ / ____ / _____ (Day/Month/Year)

Engraftment Data / Disease Status

Engraftment: ☐ Yes ☐ No Date (neutrophils > 0.5 x 10^9/L) ____ / ____ / _____ (Day/Month/Year)

In case of allogeneic SCT hematopoietic chimerism (most recent result with date):

☐ Donor ☐ Mixed ☐ Recipient ☐ Not performed Date: ____ / ____ / _____ (Day/Month/Year)

Please state percentage: donor _____% recipient _____%

Best response of disease to transplant: _____

Date achieved: ____ / ____ / _____ (Day/Month/Year)

Evaluated by: _____

Current disease status: _____ Date of assessment: ____ / ____ / _____ (Day/Month/Year)

Chromosome / PCR data (state source – marrow or blood) on disease and chimerism:

Most recent result with date:

Additional comments:

Transplant Related Complications in Recipient

GvHD: (Grade/organs involved and treatment received)

Acute ☐ Yes ☐ No Grade: _____ Resolved ☐ Yes ☐ No

Chronic ☐ Yes ☐ No Grade: _____ Resolved ☐ Yes ☐ No

Serious infection: (State type and treatment received)

Resolved ☐ Yes ☐ No

Organ toxicity / Other:

Describe type and treatment: _____

Resolved ☐ Yes ☐ No

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Current Clinical Status of Recipient

Physical examination: (state significant findings) _____

Current medication: (please list) _____

Describe any intensive medical support the recipient is receiving e.g. ventilation, dialysis etc:_____

_____

Current Recipient Condition (Laboratory Data)

(Blanks are considered to represent normal results)

WBC:	WBC Differential:	
	Neutrophils:	Blasts:
	Lymphocytes:	Others:

Hemoglobin _____g/dL Frequency of red blood cell transfusions: _____

Date of last red cell transfusion: ____ / ____ / _____
(Day/Month/Year)

Platelets _____x 10^9/L Frequency of **platelet** transfusions: _____

Date of last platelet transfusion: ____ / ____ / _____
(Day/Month/Year)

Please give the following results only if abnormal:

Urea:	mg/dL	AST:	U/L
Creatinine:	mg/dL	Alkaline Phosphatase:	U/L
Bilirubin:	mg/dL	Chest X-Ray:	

Previous Request for Subsequent Donation

Have there been previous post transplant donation requests for this donor? ☐ Yes ☐ No

If Yes, was the request approved? ☐ Yes ☐ No

If the request was refused, please state why:_____

_____

Product requested:_____

Details on Planned New Stem Cell Transplant

Planned recipient treatment (with dates): ____ / ____ / _____ (Day/Month/Year)

No. of days of conditioning prior to stem cell infusion: _____

Preferred harvest date: ____ / ____ / _____ (Day/Month/Year)

Alternative date: ____ / ____ / _____ (Day/Month/Year)

Minimum number of days prior to collection that donor clearance must be received: _____

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Details on Planned New Stem Cell Transplant (continued)

Is product manipulation planned? ☐ Yes ☐ No
If Yes, briefly describe the planned manipulation:_____

_____

Prophylaxis for GvHD:

Treatment alternative for recipient besides URD:

Is a backup marrow/PBSC or frozen marrow/PBSC available? ☐ Yes ☐ No
Is there an alternative suitable unrelated donor? ☐ Yes ☐ No
Is there an alternative suitable unrelated cord blood unit? ☐ Yes ☐ No

Please state the expected response probability for your recipient and describe the evidence for your expectation: _____

Additional Comments: _____

Product Request

Product preference: Please fill in a numeric value next to products to indicate preference:
1 = 1st preference; **2** = 2nd preference; **0** = not desired if 1st preference is not possible

☐ HPC, Marrow Preference: _____

☐ HPC, Apheresis Preference: _____

☐ MNC, Apheresis Preference: _____

☐ Unit of whole blood

REASON FOR PRODUCT PREFERENCE (please provide relevant information):

Required Documentation to Accompany This Request

1. Formal Request for Human Stem Cell Collection or Formal Request for MNC, Apheresis Form.
2. Copy of all laboratory reports listing HLA typing results of recipient and donor.
3. Completed HPC, Marrow; HPC, Apheresis or MNC, Apheresis Prescription Form(s)

Name of Person Completing Form:	Signature:
Telephone:	Fax:
Date: ____ / ____ / _____ (Day/Month/Year)	Email: