



Marrow Donor Program Belgium - Registry
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FORMAL REQUEST FOR HUMAN PERIPHERAL BLOOD LYMPHOCYTE COLLECTION
(TC, Apheresis)

(Following previous stem cell transplants only)

PATIENT DATA:

Patient name:		Patient ID number: (assigned by patient's registry)		
Patient registry:		Patient ID number: (assigned by donor's registry)		
Diagnosis:		Current disease status:		
Date of birth: (Day/Month/Year)	Gender: <input type="checkbox"/> M <input type="checkbox"/> V	Weight: kg	CMV:	Blood Group:

TRANSPLANT CENTRE:

Hospital:	Contact name:
Address:	Phone no:
	Fax no:
	Email:

DONOR DATA:

Donor ID number:		Donor's Registry:		
Date of birth: (Day/Month/Year)	Gender: <input type="checkbox"/> M <input type="checkbox"/> V	Weight: kg	CMV:	Blood Group:

PRODUCT REQUEST:

DLI: 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/> >3rd <input type="checkbox"/> If >3rd DLI, indicate no. of DLI:

PROTOCOL DATA (A brief protocol flow chart must be enclosed):

Products that are <i>included</i> in the protocol and therefore may later be requested: One DLI <input type="checkbox"/> >1 DLIs <input type="checkbox"/> (Number:) Additional BM <input type="checkbox"/> Additional PBSC <input type="checkbox"/> Other <input type="checkbox"/> (Please specify):
2nd transplant <input type="checkbox"/> >2nd transplant <input type="checkbox"/> If >2nd transplant, list types & dates of previous transplants: Did the donor being requested above previously donate stem cells on behalf of this patient? <input type="checkbox"/> yes <input type="checkbox"/> no Was any of the original stem cell product cryopreserved for later infusion? <input type="checkbox"/> yes <input type="checkbox"/> no If YES, was that product infused? <input type="checkbox"/> yes <input type="checkbox"/> no

PREFERRED DATES (in order of preference):

Collection Date		Corresponding Infusion Date	
1		1	
2		2	
3		3	

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

REQUIRED DOCUMENTATION TO ACCOMPANY THIS REQUEST

1. Detailed description of patient's post-transplantation condition.		
2. Completed Prescription for Peripheral Blood Lymphocyte Collection form.		
3. HLA matching between donor and patient comply to the Seattle criteria cfr. SOP: <input type="checkbox"/> yes <input type="checkbox"/> no (Medical Advisory Committee)		
Person Completing Form:	Signature:	Date: (Day/Month/Year)