



PRELIMINARY SEARCH REQUEST INTERNATIONAL PATIENT

Date of Request: <small>(Day/Month/Year)</small>	Type of Search to be performed: <input type="checkbox"/> Stem Cell Donors Only <input type="checkbox"/> Cord Blood Units Only <input type="checkbox"/> Stem Cell Donors & Cord Units	Is this search urgent? <input type="checkbox"/> Yes <input type="checkbox"/> No Are mismatches accepted? <input type="checkbox"/> Yes <input type="checkbox"/> No
Patient ID :	Last Name:	First Name:
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Weight: kg	CMV Status: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown
Diagnosis: (please complete disease list in attachment)		Date of Diagnosis:
Blood group:		Diagnostic comment:

Patient Class I typing results:

	A	B	C	HLA typing Labo:
First antigen:				
Second antigen:				
Testing method:	<input type="checkbox"/> Sero. <input type="checkbox"/> DNA	<input type="checkbox"/> Sero. <input type="checkbox"/> DNA	<input type="checkbox"/> Sero. <input type="checkbox"/> DNA	Date of typing:

Patient Class II typing results:

	DRB1	DRB3/4/5	DQB1	DPB1
First antigen:				
Second antigen:				
Testing method:	<input type="checkbox"/> Sero. <input type="checkbox"/> DNA	<input type="checkbox"/> Sero. <input type="checkbox"/> DNA	<input type="checkbox"/> Sero. <input type="checkbox"/> DNA	<input type="checkbox"/> Sero. <input type="checkbox"/> DNA

ARE HAPLOTYPES IDENTIFIED: YES NO

TRANSPLANT CENTER:	TRANSPLANT COORDINATOR:	
Telephone:	Fax:	Email:



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DISEASE CATEGORIE

PATIENT ID:

NAME OF PATIENT:

Acronym	Disease category	Check	Disease/stage
SAA	Severe Aplastic Anemia	<input type="checkbox"/>	Idiopathic aplasia
		<input type="checkbox"/>	Secondary post hepatic medullary aplasia
		<input type="checkbox"/>	Secondary idiopathic medullary aplasia
		<input type="checkbox"/>	Secondary toxic medullary aplasia
		<input type="checkbox"/>	Other secondary medullary aplasia
		<input type="checkbox"/>	Paroxysmal nocturnal hemoglobinuria
		<input type="checkbox"/>	Fanconi anemia
		<input type="checkbox"/>	Other constitutional aplasia
		<input type="checkbox"/>	Other non constitutional aplasia
IEA	Inherited Erythrocyte Abnormality	<input type="checkbox"/>	Sickle cell anemia
		<input type="checkbox"/>	Thalassemia
		<input type="checkbox"/>	Other: PLEASE SPECIFY:
ALL	Acute Lymphoblastic Leukaemia	<input type="checkbox"/>	1 st or 2 nd complete remission (CR)
		<input type="checkbox"/>	3 rd + CR
		<input type="checkbox"/>	1 st or 2 nd relapse
		<input type="checkbox"/>	3 rd + relapse
AML	Acute Myelogenous Leukaemia	<input type="checkbox"/>	CR
		<input type="checkbox"/>	1 st and 2 nd relapse
		<input type="checkbox"/>	3 rd + relapse
CML	Chronic Myelogenous Leukaemia	<input type="checkbox"/>	Chronic phase (CP) 1
		<input type="checkbox"/>	CP 2+
		<input type="checkbox"/>	Accelerated phase
		<input type="checkbox"/>	Blast phase
MDS	Myelodysplastic disorders	<input type="checkbox"/>	Highest IPSS<1.5
		<input type="checkbox"/>	Highest IPSS>1.5
PCD	Plasma Cell disorders	<input type="checkbox"/>	Multiple myeloma
		<input type="checkbox"/>	Leukemia with plasmocytes



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Acronym	Disease category	Check	Disease/stage
CLL	Chronic Lymphocytic Leukemia	<input type="checkbox"/>	Refractory to Fludarabine
		<input type="checkbox"/>	With Del p53 (17p-)
		<input type="checkbox"/>	None of the above
IIS	Inherited Immune System Disorder	<input type="checkbox"/>	Severe combined immunodeficiency
		<input type="checkbox"/>	Combined immunodeficiency
		<input type="checkbox"/>	Ommen syndrome
		<input type="checkbox"/>	Wiskott Aldrich syndrome
		<input type="checkbox"/>	Ataxia Telangiectasia
		<input type="checkbox"/>	Other: PLEASE SPECIFY:
HL	Hodgkin's Lymphoma	<input type="checkbox"/>	CR1
		<input type="checkbox"/>	Other
NHL	Non-Hodgkin's Lymphoma	<input type="checkbox"/>	CR1
		<input type="checkbox"/>	Other: PLEASE SPECIFY:
		Histology:	
		Grade:	
IPA	Inherited Platelet Abnormality	<input type="checkbox"/>	Amegacaryocytosis
		<input type="checkbox"/>	Glanzmann Thrombastenia
		<input type="checkbox"/>	Other : PLEASE SPECIFY:
IMD	Inherited Metabolic Disorder	<input type="checkbox"/>	Hurler Syndrom
		<input type="checkbox"/>	Adrenoleucodystrophia
		<input type="checkbox"/>	Other: PLEASE SPECIFY:
HIS	Histiocytic Disorders	<input type="checkbox"/>	Histiocytosis
		<input type="checkbox"/>	Familial lymphohistiocytosis
		<input type="checkbox"/>	Other: PLEASE SPECIFY:
OM	Other Malignancy	<input type="checkbox"/>	Myelofibrosis
		<input type="checkbox"/>	Polycythemia vera (Vaquez)
		<input type="checkbox"/>	Essential trombocytomia
		<input type="checkbox"/>	Other: PLEASE SPECIFY:
OND	Other Non-Malignant Disease	<input type="checkbox"/>	PLEASE SPECIFY: