



Marrow Donor Program Belgium - Registry
Motstraat 40 2800 Mechelen
Tel: (32) - 15 44 33 96 Fax: (32) - 15 44 36 56
Email : MDPB-registry@rodekruis.be

REQUEST MEDICAL ADVISORY COMMITTEE

**SECTION A: TO BE COMPLETED BY TRANSPLANT CENTER OR DONOR CENTER
REQUESTING MAC APPROVAL
PLEASE EMAIL OR FAX TO THE REGISTRY 0032 15 44 36 56**

Reply within 1 week

Urgent request (within 48 hours)
Please specify reason of urgency:

Patient ID:

DOB:

Donor code (if applicable):

- a. Patient's disease is not generally recommended : GNR.
Please submit the MAC request, incl. full description of the patient's disease history and reason for an URD transplant by completing section B "request for review" for review by the Medical Advisory Committee.
- b. Patient's disease belongs to category "developmental".
Please submit the MAC request, incl. full description of the patient's disease history and reason for an URD transplant by completing section B "request for review" for review by the Medical Advisory Committee.
- c. Indications for a second BM or PBSC donation (HPC,M or HPC,A) for the same recipient, same Belgian donor.
Please submit "MDPB008 second donation request v1 2010" for review by the Medical Advisory Committee.
- d. In case of a significant mismatch (<8/10), please submit the IRB approved Protocol for review by the Medical Advisory Committee.
- e. Results of the blood test doesn't comply to the blood donor requirements.
Please submit "MDPB016 donor clearance v1 2010" for review by the Medical Advisory Committee
- f. In case of cryopreservation of cells of voluntary donor (HPC,M or HPC,A), please submit reason and clinical condition of patient and expected date of transplant.
- g. Other:

MOTIVATION:

Name of physician:

Signature:

STAMP:



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SECTION B: REQUEST FOR REVIEW BY THE MEDICAL ADVISORY COMMITTEE
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(To be completed for A/B/C of section A).

Patient ID:

DOB:

Diagnosis: Histology if NHL:

Status of disease (eg CR, PR, relapse, incipient relapse, primary refractory):

Length of first remission:

Karyotype

- Normal
- Abnormal, specify:
- Not done

Previous treatments:

- | | |
|----|-----------|
| 1. | Response: |
| 2. | Response: |
| 3. | Response: |

Previous autologous or allogeneic BM/PBSC/CB transplantation:

- No Yes, specify:

Previous serious infections (eg. Fungal, CMV, hepatitis C, etc.)

- No Yes, specify:

Previous serious complications:

- No Yes, specify:

Karnofsky score:

Please describe the reason for considering URD transplantation and supply supporting publication or protocol:

Comments:



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This request will be sent to the MAC members. The members of the MAC must reply within 1 week (48 hours if urgent). A minimum of 50 % of the members has to approve the request prior to proceeding. A MAC member cannot vote on a request from his/her own center.

SECTION C: TO BE COMPLETED BY MAC MEMBERS

Patient ID:

DOB:

Donor code (if applicable):

Approval of this request

Rejection of this request

Motivation:

Name of physician:

Signature:

STAMP: