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

COLLECTION REPORT: STIMULATED HUMAN PERIPHERAL BLOOD STEM CELL
(HPC, Apheresis)
(To be completed by the collection center)

PATIENT DATA:

Patient name: Patient weight:	Patient ID number: (assigned by patient's registry)
Transplant center:	Patient ID number: (assigned by donor's registry)

DONOR DATA:

Donor ID number:		Donor Center:		
Age or date of birth: (Day/Month/Year)	Gender: ☐ M ☐ F	Weight: kg	CMV:	Blood group/Rh:

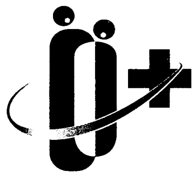
TRANSPLANT CENTER	COLLECTION CENTER
Institution:	Institution:
Address:	Address:

MOBILIZATION:

☐ G-CSF: ☐ Neupogen ☐ Granocyte
Daily dose: μg/day
Date of first dose:

APHERESIS INFORMATION:

Date: (Day/Month/year)	Time started:	Time completed:	Multi-day collection? ☐ Yes ☐ No	Collection Day of
	24 hour clock & local time zone			
1. Is CD34 enumeration performed? ☐ Yes ☐ No			Number of CD34 pos. cells (if available): X 10^6	
2. If Yes, will results be available prior to shipment? ☐ Yes ☐ No 2a.If results will not be available prior to shipment, will they be faxed to the transplant center? ☐ Yes ☐ No				
Mononuclear Cell Count:	Anticoagulant used & volume:		Other additives & volumes (including donor plasma):	
Volume Collected: ml				
Blood cell separator, model & software version (if applicable): ☐ Cobe spectra ☐ Baxter CS 3000 ☐ Other: Program used:		Number of liters of whole blood processed:		
Incident during collection? ☐ yes ☐ no If yes, give details:				
Any changes in collection requirements or additional comments?				



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Overnight storage method/details:
Transport Temperature: (Special packing materials such as gel packs must be provided by the transplant center unless alternative arrangements have been made with the donor or collection center)

MATERIAL:

Material	Commercial name	LOT number	Expiration date	Inspection	Total amount
ACD				☐ OK	ml
Heparin				☐ OK	
Collection kit				☐ OK	
				☐ OK	
				☐ OK	

CELL COUNT:

Volume collected:	ml		
NC COUNT	/ µl	TOTAL:	10^8
CD 34 +:	%		
CD 34+:	/ µl	TOTAL:	10^6
Calculated CD 34+ cell dose for recipient			
Prescribed	10^6CD34+/ kg		= 10^6CD34+/kg
Collected	10^6CD34+/ kg		= 10^6CD34+/kg

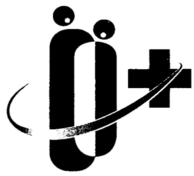
OTHER QUALITY CONTROL:

Peripheral blood WBC count: / µl

Culture for bacterial contamination: ☐ Negative / ☐ Positive / ☐ Not done

If positive: give details:

Other tests done:



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ADDITIONAL SAMPLES:

Type of sample		Prescribed	Collected
PBSC:		ml	ml
Blood:	CLOTTED (no anti-coagulant)	ml	ml
	EDTA	ml	ml
	HEPARIN	ml	ml
	ACD	ml	ml

DISCLAIMER: The cell products collected from this donor are intended solely for the purpose of immediate therapeutic treatment for the above-mentioned patient. Excess cells may be stored for future infusion for this patient. No other uses of these cells are permissible. Cells not used for the therapeutic treatment of the above mentioned patient must be disposed of properly. The donor center must be provided detailed information concerning the use and/or disposal of all portions of this cell product. By accepting these cells, the transplant physician also accepts these terms and conditions. Requests for deviations from these terms must be submitted in writing to the donor center for approval.

PROBLEM REPORTED BY TRANSPLANT CENTER:

Problem reported:

Action taken:

Collection physician: STAMP:	Signature:	Date: (Day/Month/Year)