



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

PREVIOUS TRANSPLANT HISTORY and FORMAL REQUEST for SUBSEQUENT STEM CELL COLLECTION

(To be submitted with formal request for subsequent stem cell collections)

PATIENT DATA:

Patient name:		Patient ID number: (assigned by patient's registry)		
Patient registry:		Patient ID number: (assigned by donor's registry)		
Pre-transplant diagnosis:		Disease status at time of initial transplant:		
Date of birth: (Day/Month/Year)	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Weight (kg):	CMV:	Blood Group / Rh:
Current disease status:				
Reason for subsequent donation request:				

DONOR DATA: Information on currently requested donor

Donor ID number:		Donor's Registry:		
Age or date of birth: (day/month/year)	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: kg	CMV:	Blood Group / Rh:

DATA FROM PREVIOUS TRANSPLANT:

Number of previous transplants:				
Date of last stem cell infusion: (day/month/year)	Manipulation: (state type e.g. T-cell depletion, plasma removal etc.)			
Source of stem cells for last transplant: <input type="checkbox"/> Allogeneic Marrow <input type="checkbox"/> Allogeneic PBSC <input type="checkbox"/> Cord Blood <input type="checkbox"/> Autologous <input type="checkbox"/> Related <input type="checkbox"/> Unrelated				
In case of unrelated: donor ID, source of stem cells, date of donation:				
Cell dose administered to recipient:	<u>MARROW</u> x 10 ⁸ / kg (MNC)	<u>PBSC</u> x 10 ⁶ / kg (CD34+)		
Details on conditioning treatment:	Myeloablative dose-reduced Did the conditioning regimen include TBI? <input type="checkbox"/> YES <input type="checkbox"/> NO			
GvHD prophylaxis administered:				



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DATA FROM PREVIOUS TRANSPLANT (continued):

Was any portion of the stem cell product frozen?	<input type="checkbox"/> YES <input type="checkbox"/> NO If YES, list the cell dose available:	
	Reason for freezing: <table border="1"><tr><td><u>MARROW</u> x 10⁸ / kg (MNC)</td><td><u>PBSC</u> x 10⁶ / kg (CD34+)</td></tr></table>	<u>MARROW</u> x 10 ⁸ / kg (MNC)
<u>MARROW</u> x 10 ⁸ / kg (MNC)	<u>PBSC</u> x 10 ⁶ / kg (CD34+)	
If any portion of the stem cell product was frozen, was it infused?	<input type="checkbox"/> YES <input type="checkbox"/> NO If YES, what was the date of infusion? Reason for infusion:	
Is autologous back up marrow/PBSC available?	<input type="checkbox"/> YES <input type="checkbox"/> NO Collection date: (Day/Month/Year)	

ENGRAFTMENT DATA / DISEASE STATUS

Engraftment: <input type="checkbox"/> YES <input type="checkbox"/> NO Date (neutrophils > 0.5 x 10 ⁹ /L) (Day/Month/Year)
In case of allogeneic SCT hematopoietic chimerism (most recent result with date): <input type="checkbox"/> Donor <input type="checkbox"/> Mixed <input type="checkbox"/> Recipient <input type="checkbox"/> Not performed Date: Please state percentage: donor _____% recipient _____% (Day/Month/Year)
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: Evaluated by:
Additional comments:



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TRANSPLANT RELATED COMPLICATIONS IN PATIENT:

GVHD: (Grade/organs involved and treatment received)			
Acute	<input type="checkbox"/> yes <input type="checkbox"/> no	Grade	Resolved <input type="checkbox"/> yes <input type="checkbox"/> no
Chronic	<input type="checkbox"/> yes <input type="checkbox"/> no	Grade	Resolved <input type="checkbox"/> yes <input type="checkbox"/> no
Serious infection: (State type and treatment received)			
Resolved: <input type="checkbox"/> yes <input type="checkbox"/> no			
Organ toxicity/Other:			
Describe type and treatment:			
Resolved: <input type="checkbox"/> yes <input type="checkbox"/> no			

CURRENT CLINICAL STATUS OF PATIENT:

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)		



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CURRENT RECIPIENT CONDITION (continued):

<i>Please give the following results only if abnormal:</i>			
Urea:	mg/dL	AST:	U/L
Creatinine:	mg/dL	Alkaline Phosphatase:	U/L
Bilirubin:	mg/dL	Chest X-Ray:	

PREVIOUS REQUESTS FOR SUBSEQUENT DONATION:

Has there been a previous post transplant donation request for this donor?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, was the request approved?		
If the request was refused, state why:		
Product requested:		

DETAILS ON PLANNED NEW SCT:

Planned recipient treatment: (with dates):		
No. of days of conditioning prior to stem cell infusion:		
Preferred harvest date:		
Alternative dates:		
Minimum number of days prior to collection that donor clearance must be received:		
Is product manipulation planned?:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If YES, briefly describe the planned manipulation:		
Prophylaxis for GVHD:		
<u>Treatment alternative for patient besides URD</u>		
Is a backup marrow/PBSC or frozen marrow/PBSC available?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is there an alternative suitable unrelated donor?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is there an alternative suitable unrelated cord blood unit?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Please state the expected response probability for your patient and describe the evidence for your expectation:		
Additional Comments:		



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PRODUCT REQUEST:

Product preference:	Bone Marrow (BM)	Lymphocyte (unstimulated leukopheresis)
	Stimulated PBSC	Unit of whole blood

Please fill in a numeric value next to products to indicate preference:

1=1st preference; 2=2nd preference; 0=not desired if 1st preference not possible

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 Human Peripheral Blood Lymphocyte form.
2. Copy of all laboratory reports listing HLA typing results of patient and donor.
3. Completed Marrow, PBSC or Unstimulated Leukopheresis Prescription Form(s)
A prescription form is not required for a unit of blood

Person Completing Form:	Signature:	Date: (Day/Month/Year)
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