



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

FORMAL REQUEST FOR HUMAN STEM CELL COLLECTION
(HPC, Marrow or HPC, Apheresis)
(To be completed by the transplant center)

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"/> F	Weight: kg	CMV:	Blood Group:

TRANSPLANT CENTRE:

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

DONOR DATA:

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:

PRODUCT REQUEST:

Product Preference: Human Bone Marrow (HPC, Marrow) Stimulated Human PBSC (HPC, Apheresis)
Please fill in a numeric value next to both products to indicate preference: 1=1st preference; 2=2nd preference; 0=not desired if 1st preference not possible
Reason for product preference:
Are any other donors still under consideration for donation on behalf of this patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are any other donors in the process of physical examination on behalf of this patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
If you have answered yes to either of these questions, is this donor requested for stem cell collection on this form the preferred donor? <input type="checkbox"/> Yes <input type="checkbox"/> No

PROTOCOL DATA (A brief protocol flow chart may 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):

TRANSPLANT HISTORY:

Has this patient received any previous stem cell transplants? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, specify source of stem cells: <input type="checkbox"/> Autologous <input type="checkbox"/> Related Donor <input type="checkbox"/> Allogeneic Donor <input type="checkbox"/> Cord Blood
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PREFERRED DATES (in order of preference):

For marrow harvest, list preferred harvest date. For PBSC collection, please list your preference for the first day's collection:		
Marrow Collection Date: (D/M/Y)	1 st PBSC Collection Date (D/M/Y)	Corresponding Infusion Date: (D/M/Y)
1	1	1
2	2	2
3	3	3
Minimum number of days prior to collection that donor clearance must be received:		
Number of days of conditioning prior to transplant:		
(Conditioning of patient must not be undertaken until the registry has confirmed the donor to be medically fit and the results of all screening tests are known and have been reported to, and accepted by, the transplant center).		

REQUIRED DOCUMENTATION TO ACCOMPANY THIS REQUEST

1. Final Compatibility Test Results form or copy of laboratory HLA typing results of patient and donor.		
2. Completed Marrow and/or PBSC Prescription form(s).		
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)