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| **IDENTIFICATION – PATIENT AND CBUs** | | | | | | | | | | | | | | | |
| Recipient name | |  | | | | | Transplant Centre | |  | | | DOB day/month/year | |  | |
|  | |  | | | | | | |  | | |  | |  | |
| Recipient ID assigned by TC / Registry | |  | | | | | Recipient ID assigned by Anthony Nolan | |  | | | Weight | |  | |
|  | |  | | | | |  | | |  | |
| Diagnosis | |  | | | | | Date of Diagnosis | |  | | | Disease status | |  | |
|  | |  | | | | |
| ABO/Rh | |  | | | | | CMV | |  | | | No. of remissions | |  | |
|  | | | | | | | | | | | | | | | |
| CBU ID | | |  | | | | | Cord Bank | |  | | Reserved? | | YES | NO |
|  | | | | |  | | | | | |  | |  | | |
| CBU ID | | |  | | | | | Cord Bank | |  | | Reserved? | | YES | NO |
|  | | | | | | | | | | | | | | | |
| **DNA / SAMPLE REQUIREMENTS** | | | | | | | | |  | | | | | | |
| DNA required? | | | YES | | | NO | | Proposed shipping date | |  | |  | |  | |
|  | |  | | | | | | | Conditioning start date | | |  | | | |
| Additional samples required? | | | YES | | | NO | | Please specify | |  | | Proposed shipping date | |  | |
|  | | | | | | |  | | | | | | | | |
| **DNA / Samples** to be delivered to: | | | | | | | | | |  | | | | | |
| Name | | |  | | | | | | | | | | | | |
|  | | |  | | | | | | |  | |  | | | |
| Address | | |  | | | | | | | | | | | | |
|  | | |  | | | | | | |  | |  | | | |
| E-mail | | |  | | | | | | | | | | | | |
|  | | |  | | | | | | |  | |  | | | |
| Telephone | | |  | | | | | | | Fax | |  | | | |
|  | | |  | | | | | | |  | |  | | | |
| **TRANSPLANT DETAILS** | | | | | | | | | | | | | | | |
| Proposed CBU shipment date | | | | | | | |  | |  | |  | |  | |
|  | | | |  | | | |  | |  | |  | |  | |
| Type of transplant | | | | Single cord | | | | Double cord | | Multiple cord | | Single cord with haplo-donor | | Ex-vivo expansion transplant | |
|  | | | |  | | | |  | |  | |  | |  | |
| Other, please specify | | | |  | | | | | | | | | | | |
|  | | | |  | | | |  | |  | |  | |  | |
| Conditioning start date | | | |  | | | | Conditioning agents | |  | | | | | |
|  | | | |  | | | |  | |  | |  | |  | |
| Scheduled transplant date | | | |  | | | |  | |  | |  | |  | |
|  | | | |  | | | |  | |  | |  | |  | |
| **CBU** to be delivered to | | | |  | | | |  | |  | |  | |  | |
|  | | | |  | | | |  | |  | |  | |  | |
| Name | | | |  | | | | | | | | | | | |
|  | | | |  | | | |  | |  | |  | |  | |
| Address | | | |  | | | | | | | | | | | |
|  | | | |  | | | |  | |  | |  | |  | |
| Telephone | | | |  | | | | | | Fax | |  | | | |
|  | | | |  | | | |  | |  | |  | |  | |
| **FOR QUERIES CONTACT** | | | | | | | |  | |  | |  | |  | |
|  | | |  | | | | | | |  | |  | | | |
| **TC Contact name** | | |  | | | | | **E-mail** | |  | | **Telephone** | |  | |
|  | | |  | | | | |  | |  | |  | |  | |
| **IN ADDITION TO THIS FORM PLEASE ALSO SEND PATIENT HLA TYPING REPORT** | | | | | | | | | | | | | | | |
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|  | | | | | | |
| **CONFIRMATION** |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **ALL COMMUNICATIONS TO BE VIA ANTHONY NOLAN EXCEPT IN EMERGENCY – ANTHONY NOLAN’S 24 HOUR ON CALL NUMBER IS +44 7710 599 161** | | | | | | | | | | | | | | | |
| 1. I confirm that the recipient has been fully advised of the risks involved and has given their consent. 2. Regarding the cord blood unit designated above, I verify that the ABO and Rh type, degree of HLA match, Total Nucleated Cell dose, compatibility testing results, and infectious disease results are acceptable to proceed with cord blood unit shipment for the above recipient. In addition, the necessary procedures are in place for the receipt, storage, and thawing/processing/infusion of cord blood units at this transplant centre. 3. I understand that once a cord unit has left the CB Bank, irrespective of whether or not the cord is utilised, **there are no returns** and payment is due. 4. I undertake to ensure that the dry shipper is returned to the CB Bank by return courier on receipt of the unit(s). 5. I will provide post transplantation data in compliance with the CB Bank’s stipulations. | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Physician name (typed) | |  | | | | | Signature | |  | | | Date day/month/year | |  | |