|  |
| --- |
| **RECIPIENT DETAILS** |
| Recipient name |       |
|  |  |  |  |  |  |
| DOB (day/month/year) |   | Gender | [ ]  MALE [ ]  FEMALE |
|  |  |  |  |  |  |
| ID assigned by Anthony Nolan  |       | ID assigned by recipient’s TC |       | ID assigned by recipient’s Int registry |       |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Diagnosis |   | Date of diagnosis |   |
|  |  |  |  |  |  |
| Have any unrelated donors or cord blood units been identified? |   |
|  |  |  |  |  |  |
| Reason for asking Anthony Nolan to facilitate request: |   |
|  |  |  |  |  |  |
| **RELATED DONOR DETAILS** |
| Donor name |       |
|  |  |
| GRID (if known) |   |   |   |   |  |   |   |   |   |  |   |   |   |   |  |   |   |   |   |  |   |   |   | Donor ID (if known) |       |
|  |  |  |  |  |  |
| DOB (day/month/year) |   | Gender  | [ ] MALE | [ ] FEMALE | Relationship to patient |   |
|  |  |  |  |  |  |
| Address |   |
|  |  |  |  |  |  |
| Home telephone |   | Mobile telephone |   |
|  |  |  |  |  |  |
| Email |   |
|  |  |  |  |  |  |
| Has the related donor been informed that this request has been made? | [ ] YES | [ ] NO |
|  |  |  |  |  |  |
| Has the donor been educated on potentially becoming a stem cell donor? | [ ] YES | [ ] NO |
|  |  |  |  |  |  |
| Will the related donor be able to understand instructions in English? | [ ] YES | [ ] NO |
|  |  |  |  |  |  |
| Is the related donor over 16 years old? |  | [ ] YES | [ ] NO |
|  |  |  |  |
| **VERIFICATION TYPING BLOOD SAMPLE REQUIREMENTS** (maximum 50mls) |
| Do you require VT blood samples to be drawn at medical for a **concurrent VT / WU**? *\*\* If no, high-resolution typing reports should be sent with this request* | [ ]  YES [ ]  NO |  |
|  |  |  |
| If yes, please provide sample requirements and shipment details:* **If a GIAS Transplant Centre leave the sample requirements and shipment details blank and tick here** [ ]
 |  |
|   | ml EDTA |   | ml ACD |  |  |
|  |  |  |  |  |  |
|   | ml Heparin |   | ml no anticoagulant |  |  |
|  |  |  |  |  |  |
| **Samples to be delivered to:**  |
|  |
| Name |   |
|  |  |  |  |  |  |
| Address |   |
|  |  |  |  |  |  |
|   |
|  |  |  |
| Contact Name |   |
|  |  |  |  |  |  |
| Telephone number |   |
|  |  |  |  |  |  |
| Fax |   |
|  |  |  |  |  |  |
| Email |   |
|  |  |
|  |  |  |  |  |  |

**\*\*\* NOTE FOR INTERNATIONAL REGISTRIES \*\*\***

**If the TC has ticked YES above to be a GIAS Transplant Centre please send: 4 x 6ml EDTA,1 x 6ml no anticoagulant**

**to the following address: Anthony Nolan Histocompatibility Laboratories, 77B Fleet Road, London NW3 2QU, UK**

|  |
| --- |
| **IDENTIFICATION** |
| Recipient name |   |
|  |  |  |  |  |
| ID assigned by Anthony Nolan  |   | ID assigned by recipient’s TC |   | ID assigned by recipient’s Int registry |   |
|  |  |  |  |  |  |
| Weight kg |   | ABO rh |   | CMV status |   |
|  |
| **TRANSPLANT CENTRE**  |  |
|  |
| Name |   |
|  |  |
| Address |   |
|  |  |
|  |   |
|  |  |  |  |
| Contact name |   | Fax number |   |
|  |  |  |  |
| Phone number |   | Out of hours number |   |
|  |  |  |  |
| Email |   |
|  |  |
| **DONOR IDENTIFICATION** |  |
|  |
| Donor name |   |
|  |  |  |  |  |
| GRID |   |   |   |   |  |   |   |   |   |  |   |   |   |   |  |   |   |   |   |  |   |   |   | Donor ID (if known) |   |
|  |  |  |  |  |
| Weight kg |   | ABO rh |   | CMV status |   |
|  |  |  |  |  |  |
| **PRODUCT TYPE** |  |
|  |
| \* Please fill in a numerical value next to both products to indicate preference: 1 – 1st preference 2 – 2nd preference 0 – not wanted |
| **Bone marrow (BM)**  |   | **PBSC** |   |
|  |  |  |  |
| Are any other donors in work up for this recipient?  | [ ]  Yes  | [ ]  No |
|  |  |  |
| If **yes**, is this donor the preferred donor? | [ ]  Yes  | [ ]  No |
|  |  |  |
| Is this donor requested to consent to participate in an AN-approved clinical trial?  | [ ]  Yes  | [ ]  No |
|  |  |
| If yes, what is the name of the trial?  |   |
|  |  |
| **PREFERRED DATES (in order of preference)** |  |
|  |
| For BM list preferred date of collection, for PBSC list preferred first date of collection |
| **Collection date: (day/month/year)** | **Corresponding infusion date: (day/month/year)** |
|  |  |
|  |   |  |   |
|  |  |  |  |
|  |   |  |   |
|  |  |  |  |
|  |   |  |   |
|  |  |  |  |
| Minimum number of days clearance must be received prior to collection  |   |
|  |  |
| Number of days recipient conditioning required prior to transplant  |   |
|  |  |
| Date donor clearance is required by for first choice dates |   |
|  |  |
| **REQUIRED DOCUMENTATION: please include copies of recipient and donor high resolution tissue typing reports, and HLA typing form**  |
| Name of individual completing form |   | Signature  |  | Date day/month/year |   |

|  |
| --- |
| **IDENTIFICATION** |
| Recipient name |   |
|  |
| ID assigned by Anthony Nolan  |   | ID assigned by recipient’s TC |   | ID assigned by recipient’s Int registry |   |
|  |  |  |  |  |  |
| Donor name |   |
|  |  |  |  |  |  |
| GRID |   |   |   |   |  |   |   |   |   |  |   |   |   |   |  |   |   |   |   |  |   |   |   | Donor ID |   |
|  |  |  |  |  |  |
| **PRE-COLLECTION PERIPHERAL BLOOD SAMPLES** (maximum 100 ml) **Note**: This blood will be drawn at the donor’s medical unless otherwise requested |
|   | ml EDTA |   | ml ACD | Other samplesPlease specify type/amount |   |
|  |  |  |  |  |  |
|   | ml Heparin |   | ml no anticoagulant |  |  |
|  |  |
| **Samples** to be delivered to | **Product** to be delivered to |
| Name |   | Name |   |
|  |  |  |  |
| Address |   | Address |   |
|  |  |  |  |
|  |   |  |   |
|  |  |  |  |
| Contact name |   | Contact name |   |
|  |  |  |  |
| Phone number |   | Phone number |   |
|  |  |  |  |
| After hours number |   | After hours number |   |
|  |  |  |  |
| Fax |   | Fax |   |
|  |  |  |  |
| Email |   | Email |   |
|  |  |  |  |
| STIMULATED PBSC COLLECTION |
| CD34+ cells per kg requested |   | x 10 ^6/kg |
|  |  |  |
| x recipient weight (kg) |   | kg |
|  |  |  |
| = total number of CD34+ cells |   | x 10 ^6 |
|  |  |  |
| + CD34+ cells for quality testing  |   | x 10 ^6 |
|  |  |  |
| = total number of CD34+ cells for recipient |   | x 10 ^6 |
|  |  |  |
| **Note i : If autologous plasma is not available for dilution HAS will be used;**  | **Note ii: Product will be transported cooled with ice packs** |
| For Anthony Nolan donors: we will aim for a CD34+ cell count of **4 x 10^6/kg**. A brief explanation is required if a higher dose than **5** is requested: |
|  |
| **CELL DILUTION         Cells must be diluted with plasma to a final TNC concentration of <200 x 10^6/ml** |
|

|  |  |
| --- | --- |
| **Comments:** | 1. **Aim for a haemocrit level of less than 4%**
2. **Leave a 10-20cm bleed line on each bag for sterile clamping & docking**
 |

 |
| **Any additional comments:** |
|  |
|  |
| **PERIPHERAL BLOOD SAMPLES TO BE COLLECTED AT FIRST APHERESIS** (maximum 100 ml) |
|   | ml EDTA |   | ml ACD | Other samplesPlease specify type/amount |   |
|  |  |  |  |  |  |
|   | ml Heparin |   | ml no anticoagulant | Additional plasma Please specify amount in ml |   |
|  |
| Clinical prescriber completing form |   | Signature  |  | Date day/month/year |  |

|  |
| --- |
| **IDENTIFICATION** |
| Recipient name |   |
|  |
| ID assigned by Anthony Nolan  |   | ID assigned by recipient’s TC |   | ID assigned by recipient’s Int registry |   |
|  |  |  |  |  |  |
| Donor name |   |
|  |  |  |  |  |  |
| GRID |   |   |   |   |  |   |   |   |   |  |   |   |   |   |  |   |   |   |   |  |   |   |   | Donor ID |   |
|  |  |  |  |  |  |
| **PRE-COLLECTION PERIPHERAL BLOOD SAMPLES** (maximum 100 ml) **Note**: This blood will be drawn at the donor’s medical unless otherwise requested |
|   | ml EDTA |   | ml ACD | Other samplesPlease specify type/amount |   |
|  |  |  |  |  |  |
|   | ml Heparin |   | ml no anticoagulant |  |  |
|  |  |
| **Samples** to be delivered to | **Product** to be delivered to |
| Name |   | Name |   |
|  |  |  |  |
| Address |   | Address |   |
|  |  |  |  |
|  |   |  |   |
|  |  |  |  |
| Contact name |   | Contact name |   |
|  |  |  |  |
| Phone number |   | Phone number |   |
|  |  |  |  |
| After hours number |   | After hours number |   |
|  |  |  |  |
| Fax |   | Fax |   |
|  |  |  |  |
| Email |   | Email |   |
|  |  |  |  |
| Note: Please fax collection report to DonorProvision@anthonynolan.org |
| BONE MARROW COLLECTION |
| Nucleated cells per kg requested |   | x 10 ^8/kg |
|  |  |  |
| x recipient weight (kg) |   | kg |
|  |  |  |
| = total number of nucleated cells |   | x 10 ^8 |
|  |  |  |
| + nucleated cells for quality testing  |   | x 10 ^8 |
|  |  |  |
| = total number of nucleated cells for recipient |   | x 10 ^8 |
|  |  |  |
| Anticoagulant  |   |
|  |  |
| Transport temperature | [ ]  Cooled (with ice packs) | [ ]  Room Temperature |
|  |  |
| Additional comments |   |
|  |
| **PERIPHERAL BLOOD SAMPLES TO BE COLLECTED AT TIME OF COLLECTION** (maximum 100 ml) |
|   | ml EDTA |   | ml ACD | Other samplesPlease specify type/amount |   |
|  |  |  |  |  |  |
|   | ml Heparin |   | ml no anticoagulant |  |  |
|  |
| Clinical prescriber completing form |   | Signature  |  | Date day/month/year |  |