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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **RECIPIENT IDENTIFICATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| ID assigned by Anthony Nolan |  | | | | | | | | | ID assigned by recipient TC | | | | | | | | |  | | | | | | | | | | ID assigned by Int registry | | |  | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DOB day/month/year |  | | | | | | | | |  | | | | | | | | | Gender | | | | | | | | | | Male | | | Female | | | |
|  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| ABO rh |  | | | | | | | | | CMV status | | | | | | | | |  | | | | | | | | | | Weight kg | | |  | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Pre-transplant diagnosis | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Disease status at time of initial transplant | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Current disease status | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Reason for subsequent donation request | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DONOR IDENTIFICATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| GRID | |  |  |  |  |  |  |  |  | |  |  |  |  |  |  | |  | |  |  |  |  |  | |  |  |  | | Donor ID | | |  | |
|  |  | | | | | | | | |  | | | | | | | | |  | | | | | | | | | |  | | |  | | | |
| Gender | Male  Female | | | | | | | | | ABO rh | | | | | | | | |  | | | | | | | | | | CMV status | | |  | | | |
|  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DATA FROM PREVIOUS TRANSPLANT** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Number of previous transplants | | | | | | | | | |  | | | | | | | | | Date of last transplant day/month/year | | | | | | | | | | | | |  | | | |
|  | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | | | | |  | | | |
| Manipulation state type e.g. T-cell depletion, plasma removal etc. | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Source of stem cells for last transplant | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **If unrelated donor**: Donor ID | | | | | | | | | |  | | | | | | | Source of stem cells | | | | | | | |  | | | | | | Collection date | | |  | |
|  | | | | | | | | | |  | | | | | | |  | | | | | | | |  | | | | | |  | | |  | |
| Cell dose administered to recipient | | | | | | | | | | Marrow | | | | | | | | | x 10^8 / kg TNC | | | | | | | | | | PBSC | | | x 10^6 / kg CD34+ | | | |
|  | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | |  | | |  | | | |
| Details on conditioning treatment | | | | | | | | | | Myeloablative | | | | | | | | | | | | | | | | | | | Dose-reduced | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | | | | | |
| Did the conditioning regimen include TBI | | | | | | | | | | Yes | | | | | | | | | | | | | | | | | | | No | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | | | | | |
| GvHD prophylaxis administered | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Was any portion of the product frozen | | | | | | | | | | Yes | | | | | | | | | | | | | | | | | | | No | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | | | | | |
| Reason for freezing | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| If **yes**, list the cell dose available: | | | | | | | | | | Marrow | | | | | | | | | x 10^8 / kg TNC | | | | | | | | | | PBSC | | | x 10^6 / kg CD34+ | | | |
|  | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | |  | | |  | | | |
| If any portion of the stem cell product was frozen, was it infused | | | | | | | | | | Yes | | | | | | | | | | | | | | | | | | | No | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | | | | | |
| If **yes,** what was the date of infusion | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Reason for infusion | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is autologous back up marrow / PBSC available | | | | | | | | | | Yes | | | | | | | | | No | | | | | | | | | | Collection date  day/month/year | | |  | | | |
|  | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | |  | | |  | | | |

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|  | | | | | | | | | | | | |
| **ENGRAFTMENT DATA / DISEASE STATUS** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Engraftment neutrophils > 0.5 x 10^9/L | | | |  | | | | | Date | |  | |
|  | |  | |  | | |  | |  | |  | |
| In case of allogeneic SCT hematopoietic chimerism most recent result with date | | | |  | | | | | Date | |  | |
|  | |  | |  | | |  | |  | |  | |
| Please state percentage | | | | Donor: % | | | Recipient: % | | Date | |  | |
|  | |  | |  | | |  | |  | |  | |
| Best response of disease to transplant | | | |  | | | | | Date achieved | |  | |
|  | |  | |  | | |  | |  | |  | |
| Evaluated by | | | |  | | | | | | | | |
|  | |  | |  | | |  | |  | |  | |
| Current disease status | | | |  | | | | | Date of assessment | |  | |
|  | |  | |  | | |  | |  | |  | |
| Chromosome / PCR data on disease and Chimerism | | | | Yes | | | No | |  | |  | |
|  | |  | |  | | |  | |  | |  | |
| State source | | | | Marrow | | | Blood | |  | |  | |
|  | |  | |  | | |  | |  | |  | |
| Most recent result with date | | | |  | | | | | Date | |  | |
|  | |  | |  | | |  | |  | |  | |
| Evaluated by | | | |  | | | | | | | | |
|  | |  | |  | | |  | |  | |  | |
| Additional comments | | | |  | | | | | | | | |
|  | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **TRANSPLANT RELATED COMPLICATIONS IN PATIENT** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **GVHD** Grade/organs involved and treatment received | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Organs |  | | Acute | |  | Grade | |  | | Resolved | |  |
|  |  | |  | |  |  | |  | |  | |  |
| Organs |  | | Chronic | |  | Grade | |  | | Resolved | |  |
|  |  | |  | |  |  | |  | |  | |  |
| **Serious infection** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| State type and treatment received | | | |  | | | | | | | | |
|  | | | |  | | |  | |  | |  | |
| Resolved | | | | Yes | | | No | |  | |  | |
|  | |  | |  | | |  | |  | |  | |
| **Organ toxicity/other** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Describe type and treatment | | | |  | | | | | | | | |
|  | | | |  | | |  | |  | |  | |
| Resolved | | | | Yes | | | No | |  | |  | |
|  | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **CURRENT CLINICAL STATUS OF PATIENT** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Physical examination state significant findings | | | | | | |  | | | | | |
|  | | | | | | |  | | | | | |
| Current medicationplease list | | | | | | |  | | | | | |
|  | | | | | | |  | | | | | |
| Describe any intensive medical support the recipient is receiving e.g. ventilation, dialysis, etc. | | | | | | |  | | | | | |
|  | | | | | | |  | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | |
| **CURRENT RECIPIENT CONDITION Laboratory Data** | | | | | | | |
|  | | | |  | | | |
| Blanks will be taken to represent normal results | | | | | | | |
|  | | | |  | | | |
| WBC |  | | WBC Differential: |  | Neutrophils | |  |
|  |  | |  |  |  | |  |
| Blasts |  | | Lymphocytes |  | Others | |  |
|  |  | |  |  |  | |  |
| Haemoglobin | g/dL | | Frequency of red blood cell transfusions |  | Date of last red cell transfusion | |  |
|  |  | |  |  |  | |  |
| Platelets | x 10^9/L | | Frequency of platelet transfusions |  | Date of last platelet transfusion | |  |
|  |  | |  |  |  | |  |
| Please give the following results **only if abnormal** | | | | | | | |
|  |  | |  |  |  | |  |
| Urea | mg/dL | | Bilirubin | mg/dL | Creatinine | | mg/dL |
|  |  | |  |  |  | |  |
| AST | U/L | | Alkaline Phosphatase | U/L | Chest X-Ray | |  |
|  |  | |  |  |  | |  |
|  | | | | | | | |
|  | | | | | | | |
| **PREVIOUS REQUESTS FOR SUBSEQUENT DONATION** | | | | | | | |
|  | | | |  | | | |
| Has there been a previous post transplant donation request for this donor | | | Yes | | No | | |
|  |  | |  |  |  | |  |
| Product requested | | |  | | | | |
|  |  | |  |  |  | |  |
| If **yes**, was the request approved | | |  | | | | |
|  |  | |  |  |  | |  |
| If the request was refused please state why | | |  | | | | |
|  |  | |  |  |  | |  |
|  |  | |  |  |  | |  |
| **PRODUCT REQUEST** | | | | | | | |
|  | | | |  | | | |
| \* Please fill in a numerical value next to **ALL** products to indicate preference: **1** – 1st preference **2** – 2nd preference **0** – not wanted | | | | | | | |
|  | | | |  | | | |
| Bone marrow BM | | |  | PBSC Peripheral Blood Stem Cells | | |  |
|  |  | |  |  |  | |  |
| Lymphocyte unstimulated leucopheresis | | |  | Blood samples specify type and amount | | |  |
|  | |  | |  | |  | |
| 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)** | | | |
|  | | | |  | | | |
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|  |  | |  |  |  | |  |
| 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 | | | |  | | | |
|  |  | |  |  |  | |  |

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| --- | --- | --- | --- | --- | --- | --- |
|  | | |  | | | |
| **DETAILS ON PLANNED NEW SCT** | | |  | | | |
|  | | | |
|  |  |  |  |  | |  |
| Is product manipulation planned | | | Yes | | No | |
|  | | |  |  | |  |
| If **yes,** briefly describe the planned manipulation | | |  | | | |
|  | |  | | | | |
| Prophylaxis for GVHD | | |  | | | |
|  |  |  |  |  | |  |
| **Treatment alternative for patient besides related donor** | | | | | | |
|  |  |  |  |  | |  |
| Is backup marrow / PBSC **or** frozen marrow / PBSC available | | | Yes – if yes, what is available? | | No | |
|  |  |  |  |  | |  |
| Is there an alternative suitable unrelated donor | | | Yes | | No | |
|  |  |  |  |  | |  |
| Is there an alternative suitable unrelated cord blood unit | | | Yes | | No | |
|  |  |  |  |  | |  |
| Please state the expected response probability for your patient and describe the evidence for your expectation | | |  | | | |
|  | | |  |  | |  |
| Additional Comments | | |  | | | |
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|  | | |  | | | |
| **TRANSPLANT CENTRE** | | |  | | | |
|  | | | |
|  |  |  |  |  | |  |
| Name |  | | | | | |
|  |  |  |  |  | |  |
| Address |  | | | | | |
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|  |  |  |  |  | |  |
| Contact name |  | | Fax number |  | | |
|  |  |  |  |  | |  |
| Phone number |  | | Out of hours number |  | | |
|  |  |  |  |  | |  |
| Email |  | | | | | |
|  |  |  |  |  | |  |
| **REQUIRED DOCUMENTATION: please include BM / PBSC / DLC Prescription form(s)** | | | | | | |
|  |  |  |  |  | |  |
| **ALL COMMUNICATION TO BE THROUGH ANTHONY NOLAN EXCEPT IN EMERGENCY** | | | | | | |
|  |  |  |  |  | |  |
| Name of individual completing form |  | Signature |  | Date day/month/year | |  |
|  |  |  |  |  | |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **IDENTIFICATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Recipient name | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ID assigned by Anthony Nolan | |  | | | | | | | | | ID assigned by recipient’s TC | | | | | | | | | | |  | | | | | | | | ID assigned by recipient’s Int registry |  |
|  | |  | | | | | | | | |  | | | | | | | | | | |  | | | | | | | |  |  |
| 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 samples  Please specify type/amount | | | | | | | |  | |
|  |  | | | | |  | | | | | | |  | | | | | | | | |  | | | | | | | |  | |
|  | ml Heparin | | | | |  | | | | | | | ml no anticoagulant | | | | | | | | |  | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
| **Samples** to be delivered to | | | | | | | | | | | | | | | | | | | | | | **Product** to be delivered to | | | | | | | | | |
| Name | |  | | | | | | | | | | | | | | | | | | | | Name | | | | | | | |  | |
|  | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | |
| Address | |  | | | | | | | | | | | | | | | | | | | | Address | | | | | | | |  | |
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| Contact name | |  | | | | | | | | | | | | | | | | | | | | Contact name | | | | | | | |  | |
|  | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | |
| Phone number | |  | | | | | | | | | | | | | | | | | | | | Phone number | | | | | | | |  | |
|  | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | |
| After hours number | |  | | | | | | | | | | | | | | | | | | | | After hours number | | | | | | | |  | |
|  | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | |
| Fax | |  | | | | | | | | | | | | | | | | | | | | Fax | | | | | | | |  | |
|  | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | |
| Email | |  | | | | | | | | | | | | | | | | | | | | Email | | | | | | | |  | |
|  | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | |
| Note: Please fax collection report to product delivery fax number above and to AN on 0044 20 7284 8226 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PERIPHERAL BLOOD LYMPHOCYTE COLLECTION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CD3+ cells per kg requested | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | x 10 ^6/kg | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | |
| x recipient weight (kg) | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | kg | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | |
| = total number of CD3+ cells | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | x 10 ^6 | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | |
| + CD3+ cells for quality testing | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | x 10 ^6 | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | |
| = total number of CD3+ cells for recipient | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | x 10 ^6 | |
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| **Note: Product will be transported cooled with ice packs** | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
| Additional comments: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
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| **PERIPHERAL BLOOD SAMPLES TO BE COLLECTED AT FIRST APHERESIS** (maximum 100 ml) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | ml EDTA | | | | |  | | | | | | | ml ACD | | | | | | | | | Other samples  Please specify type/amount | | | | | | | |  | |
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|  | ml Heparin | | | | |  | | | | | | | ml no anticoagulant | | | | | | | | | Additional plasma Please specify amount in ml | | | | | | | |  | |
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| Clinical prescriber completing form | |  | | | | | | | | | Signature | | | | | | | | | |  | | | | | | | | | Date day/month/year |  |

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| **IDENTIFICATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Recipient name | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ID assigned by Anthony Nolan | |  | | | | | | | | | ID assigned by recipient’s TC | | | | | | | | | | |  | | | | | | | | ID assigned by recipient’s Int registry |  |
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| **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 samples  Please specify type/amount | | | | | | | |  | |
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| **Samples** to be delivered to | | | | | | | | | | | | | | | | | | | | | | **Product** to be delivered to | | | | | | | | | |
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| Note: Please fax collection report to product delivery fax number above and to AN on 0044 20 7284 8226 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| STIMULATED PBSC COLLECTION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CD34+ cells per kg requested | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | x 10 ^6/kg | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | |
| x recipient weight (kg) | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | kg | |
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| = total number of CD34+ cells | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | x 10 ^6 | |
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| + CD34+ cells for quality testing | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | x 10 ^6 | |
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| = total number of CD34+ cells for recipient | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | x 10 ^6 | |
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| **Note i : If autologous plasma is not available for dilution HAS will be used;** | | | | | | | | | | | | | | | | | | | | | | **Note ii: Product will be transported cooled with ice packs** | | | | | | | | | |
| Anthony Nolan will aim for a CD34+ cell count of **4 x 10^6/kg**. A brief explanation is required if a higher dose is requested: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Additional Comments** | | | | | | | | | | | **Aim for a haemocrit level of less than 4%**  **Dilute cells with plasma to final minimal volume of <200 x 10^6/ml**  **10-20cm bleed line to be left on each bag for sterile clamping & docking** | | | | | | | | | | | | | | | | | | | | |
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| **PERIPHERAL BLOOD SAMPLES TO BE COLLECTED AT FIRST APHERESIS** (maximum 100 ml) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | ml EDTA | | | | |  | | | | | | | ml ACD | | | | | | | | | Other samples  Please specify type/amount | | | | | | | |  | |
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|  | ml Heparin | | | | |  | | | | | | | ml no anticoagulant | | | | | | | | | Additional plasma Please specify amount in ml | | | | | | | |  | |
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| Clinical prescriber completing form | |  | | | | | | | | | Signature | | | | | | | | | |  | | | | | | | | | Date day/month/year |  |

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| **IDENTIFICATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Recipient name | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ID assigned by Anthony Nolan | |  | | | | | | | | | ID assigned by recipient’s TC | | | | | | | | | | |  | | | | | | | | ID assigned by recipient’s Int registry |  |
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| GRID | |  |  |  |  | |  |  |  |  | |  | |  |  |  |  |  |  |  | | |  |  |  |  |  |  |  | Donor ID |  |
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| **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 samples  Please specify type/amount | | | | | | | |  | |
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|  | ml Heparin | | | | |  | | | | | | | ml no anticoagulant | | | | | | | | |  | | | | | | | |  | |
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| **Samples** to be delivered to | | | | | | | | | | | | | | | | | | | | | | **Product** to be delivered to | | | | | | | | | |
| Name | |  | | | | | | | | | | | | | | | | | | | | Name | | | | | | | |  | |
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| Note: Please fax collection report to product delivery fax number above and to AN on 0044 20 7284 8226 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BONE MARROW COLLECTION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nucleated cells per kg requested | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | x 10 ^8/kg | |
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| x recipient weight (kg) | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | kg | |
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| = total number of nucleated cells for recipient | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | x 10 ^8 | |
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| Transport temperature | | | | | | | | | | | Cooled (with ice packs) | | | | | | | | | | | | | | | | | | | Room Temperature | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Additional comments | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
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| **PERIPHERAL BLOOD SAMPLES TO BE COLLECTED AT TIME OF HARVEST(** (maximum 100 ml) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | ml EDTA | | | | |  | | | | | | | ml ACD | | | | | | | | | Other samples  Please specify type/amount | | | | | | | |  | |
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|  | ml Heparin | | | | |  | | | | | | | ml no anticoagulant | | | | | | | | |  | | | | | | | |  | |
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| Clinical prescriber completing form | |  | | | | | | | | | Signature | | | | | | | | | |  | | | | | | | | | Date day/month/year |  |