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| **RECIPIENT DETAILS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Recipient name |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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 |  | |
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| Diagnosis |  | | | | | | | | | | | | | | | | | | | | | | | | | | | Date of diagnosis |  | |
|  |  | | | | | | | |  | | | | | | | | |  | | | | | | | | | |  |  | |
| Have any unrelated donors or cord blood units been identified? | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  |  | | | | | | | |  | | | | | | | | |  | | | | | | | | | |  |  | |
| Reason for asking Anthony Nolan to facilitate request: | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| **RELATED DONOR DETAILS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Donor name |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| GRID (if known) |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  | |  | |  |  |  |  |  |  | | Donor ID (if known) |  | |
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| DOB (day/month/year) |  | | | | | | | | Gender | | | | | | | | | MALE | | | | | FEMALE | | | | | Relationship to patient |  | |
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| Address |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Home telephone |  | | | | | | | | | | | | | | | | | Mobile telephone | | | | | | | | | |  | | |
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| Email |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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 | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | |
| If no, please advise of the related donors first language so a translator can be arranged | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | |
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| Is the related donor over 16 years old? | | | | | | | | | | | | | | | | | |  | | | | | | | | | | YES | NO | |
|  | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  |  | |
| **CONCURRENT VT / WUs** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 you have already requested samples for VT via Anthony Nolan, please do not complete the below.  For non-GIAS TCs - If yes, please provide sample requirements and shipment details below  **For GIAS Transplant Centres - please leave the sample requirements and shipment details blank and tick here**  **For External Registries - If the TC has ticked above to advise they are 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** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
|  | ml EDTA | | | | | | | |  | | | | | | | | | ml ACD | | | | | | | | | |  |  | |
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|  | ml Heparin | | | | | | | |  | | | | | | | | | ml no anticoagulant | | | | | | | | | |  |  | |
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| **Samples to be delivered to:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Name |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Telephone number |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Name of individual 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 |  |
|  | |  | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | |  |  |
| Weight kg | |  | | | | | | | | | | ABO rh | | | | | | | | | | |  | | | | | | | | CMV status |  |
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| **TRANSPLANT CENTRE** | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Contact name | |  | | | | | | | | | | | | | | | | | | | | | Fax number | | | | | | | |  | |
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| Phone number | |  | | | | | | | | | | | | | | | | | | | | | Out of hours number | | | | | | | |  | |
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| Email | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **DONOR IDENTIFICATION** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Donor name | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| GRID | |  |  | |  | |  |  |  |  |  | |  | |  |  |  |  |  |  |  | | |  |  |  |  |  |  |  | Donor ID (if known) |  |
|  | |  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |  |  |
| Weight kg | |  | | | | | | | | | | ABO rh | | | | | | | | | | |  | | | | | | | | CMV status |  |
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| **PRODUCT TYPE** |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| \* 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? | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
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| **PREFERRED DATES (in order of preference)** | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
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| 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 | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
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| Number of days recipient conditioning required prior to transplant | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
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| Date donor clearance is required by for first choice dates | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
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| **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 |  |

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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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| Donor name | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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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 | | | | | | | |  | |
|  |  | | | | |  | | | | | | |  | | | | | | | | |  | | | | | | | |  | |
|  | 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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| Address | |  | | | | | | | | | | | | | | | | | | | | Address | | | | | | | |  | |
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| Contact name | |  | | | | | | | | | | | | | | | | | | | | Contact name | | | | | | | |  | |
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| Phone number | |  | | | | | | | | | | | | | | | | | | | | Phone number | | | | | | | |  | |
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| 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 | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | |
| + 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:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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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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| Donor name | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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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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| Contact name | |  | | | | | | | | | | | | | | | | | | | | Contact name | | | | | | | |  | |
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| Phone number | |  | | | | | | | | | | | | | | | | | | | | Phone number | | | | | | | |  | |
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| After hours number | |  | | | | | | | | | | | | | | | | | | | | After hours number | | | | | | | |  | |
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| Fax | |  | | | | | | | | | | | | | | | | | | | | Fax | | | | | | | |  | |
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| Note: Please fax collection report to DonorProvision@anthonynolan.org | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | x 10 ^8 | |
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| + nucleated cells for quality testing | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | x 10 ^8 | |
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| = total number of nucleated cells for recipient | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | x 10 ^8 | |
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| Anticoagulant | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
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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 COLLECTION** (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 |  |