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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 |   |  | Sex  | [ ]  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 |       |
|  |  |  |  |  |  |
| Sex | [ ]  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 dateday/month/year |  |
|  |  |  |  |  |

|  |
| --- |
|  |
| **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)** |
|  |  |
|  |   |  |   |
|  |  |  |  |
|  |   |  |   |
|  |  |  |  |
|  |   |  |   |
|  |  |  |  |  |  |
| 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 |   |
|  |  |  |  |  |  |
|  |
| **CRYOPRESERVATION**  |
|  |
| Do you plan to cryopreserve all the cells? | [ ]  Yes [ ]  No |
|  |  |
| If yes, please tick reason (one option only) | [ ]  Covid-19[ ]  Patient reasons[ ]  Donor reasons | [ ]  Logistical reasons[ ]  Other |
|  |  |  |
| Please provide a short explanation for selecting the above reason  |   |

|  |  |
| --- | --- |
|  |  |
| **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 |   |
|  |  |  |  |  |  |
|  |  |
|  |  |
| **TRANSPLANT CENTRE** |  |
|  |
|  |  |  |  |  |  |
| Name |   |
|  |  |  |  |  |  |
| Address |   |
|   |  |  |  |  |  |
|  |   |
|  |  |  |  |  |  |
|  |   |
|  |  |  |  |  |  |
| 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 |   |
|  |  |  |  |  |  |

|  |
| --- |
| **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 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 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 |   | x 10 ^6 |
|  |  |  |
| **Note: Product will be transported cooled with ice packs** |  |
| 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 |   |
|  |  |  |  |  |  |
| 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 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 |
|  |  |  |
| = total number of CD34+ cells |   | x 10 ^6 |
|  |  |  |
| + CD34+ cells for quality testing  |   | x 10 ^6 |
|  |  |  |
| = total number of CD34+ cells |   | 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 count of **6 or higher** is requested: |
|  |
|   |
| **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** |
| **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 |   |
|  |  |  |  |  |  |
| 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 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 |
|  |  |  |
| 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 |   | x 10 ^8 |
|  |  |  |
| Anticoagulant  |   |
|  |  |
| Transport temperature | [ ] Cooled (with ice packs) | [ ] Room Temperature |
|  |  |
| Additional comments |   |
|  |
| **PERIPHERAL BLOOD SAMPLES TO BE COLLECTED AT TIME OF HARVEST(** (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 |  |