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| **RECIPIENT IDENTIFICATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Recipient name | |  | | | | | | | | | | | | | | | | | | | | | Sex | | | | | | | | Male | | Female |
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| ID assigned by Anthony Nolan | |  | | | | | | | | | | ID assigned by recipient’s TC | | | | | | | | | | |  | | | | | | | | ID assigned by recipient’s Int registry | |  |
|  | |  | | | | | | | | | |  | | | | | | | |  |
| DOB day/month/year | |  | | | | | | | | | | Diagnosis | | | | | | | | | | |  | | | | | | | | | | |
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| Weight kg | |  | | | | | | | | | | ABO rh | | | | | | | | | | |  | | | | | | | | CMV status | |  |
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| Has the patient previously received a stem cell transplant from an alternative donor or any other allogeneic cellular therapy (related or unrelated)? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| If yes, provide details | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **TRANSPLANT CENTRE** | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Contact name | |  | | | | | | | | | | | | | | | | | | | | | Fax number | | | | | | | |  | | |
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| **DONOR IDENTIFICATION** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Sex | | Male  Female | | | | | | | | | | 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 |
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| 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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| **CRYOPRESERVATION**  **CRYOPRESERVATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Do you plan to cryopreserve the cells? | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | |
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| 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 | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
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| **RECIPIENT VT** | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| Please confirm if recipient verification typing has been performed? | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | |
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| If no, is this in progress? please provide details | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
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| **CONCURRENT DONOR VT / WUs** | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
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| Do you require VT blood samples to be drawn at medical for a **concurrent VT / WU**? \*\* | | | | | Yes  No |  |
| \*\* If you have already requested VT samples via Anthony Nolan do not complete anything below.   * **For GIAS Transplant Centres: please leave the sample requirements/shipment details below blank and tick here**   **For International Registries: If the TC has ticked above to advise they are a GIAS Transplant Centre please send:**  **2 x 4ml EDTA**  **1 x 4ml no anticoagulant**  **to the following address: Anthony Nolan Histocompatibility Laboratories, 77B Fleet Road, London NW3 2QU, UK**   * **For non-GIAS TCs: If yes, VT blood samples are required, please provide sample requirements and shipment details below:** | | | | | |
|  | | | | | |
|  | | | | | |
|  | ml EDTA |  | ml ACD | | |
|  |  |  |  |  |  |
|  | ml Heparin |  | ml no anticoagulant | | |
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| **Samples** to be delivered to: | | | |  |  |
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| **REQUIRED DOCUMENTATION:**  **please include copies of recipient and donor high-resolution tissue typing reports (unless this is a concurrent VT / WU and high-resolution typing reports are not yet available)** | | | | | |
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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 |  |
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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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| 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 | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | 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** | | | | | | | | | |
| 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: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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 | | | | | | | |  | |
|  |  | | | | |  | | | | | | |  | | | | | | | | |  | | | | | | | |  | |
|  | ml Heparin | | | | |  | | | | | | | ml no anticoagulant | | | | | | | | | Additional plasma Please specify amount in ml | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of clinical prescriber | |  | | | | | | | | | 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | 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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| 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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| Anticoagulant | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
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| Transport temperature | | | | | | | | | | | Cooled (with ice packs) | | | | | | | | | | | | | | | | | | | Room Temperature | |
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| Additional comments | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
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| **PERIPHERAL BLOOD SAMPLES TO BE COLLECTED AT TIME OF COLLECTION** (maximum 100 ml) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | ml EDTA | | | | |  | | | | | | | ml ACD | | | | | | | | | Other samples  Please specify type/amount | | | | | | | |  | |
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|  | ml Heparin | | | | |  | | | | | | | ml no anticoagulant | | | | | | | | |  | | | | | | | |  | |
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| Name of clinical prescriber | |  | | | | | | | | | Signature | | | | | | | | | |  | | | | | | | | | Date day/month/year |  |