|  |
| --- |
| **RECIPIENT IDENTIFICATION** |
| Recipient name |       | Sex | [ ]  Male  | [ ]  Female |
|  |  |  |  |  |
| ID assigned by Anthony Nolan  |       | ID assigned by recipient’s TC |       | ID assigned by recipient’s Int registry |       |
|  |  |  |  |
| DOB day/month/year |   | Diagnosis |   |
|  |  |
| Weight kg |   | ABO rh |   | CMV status |   |
|  |  |  |  |  |  |
| 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 |  |
|  |
| **TRANSPLANT CENTRE**  |  |
|  |
| Name |   |
|  |  |
| Address |   |
|  |  |
|  |   |
|  |  |
|  |   |
|  |  |  |  |
| Contact name |   | Fax number |   |
|  |  |  |  |
| Phone number |   | Out of hours number |   |
|  |  |  |  |
| Email |   |
|  |  |
| **DONOR IDENTIFICATION** |  |
|  |
| GRID |   |   |   |   |  |   |   |   |   |  |   |   |   |   |  |   |   |   |   |  |   |   |   |  |       |
|  |  |  |  |  |
| Sex | [ ]  Male [ ]  Female | 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 |   |
|  |  |
|  |  |
|  |  |
| **CRYOPRESERVATION** **CRYOPRESERVATION**  |
|  |  |
| Do you plan to cryopreserve 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  |   |
|  |  |
| **RECIPIENT VT**  |  |
| Please confirm if recipient verification typing has been performed? | [ ]  Yes [ ]  No |
|  |  |
| If no, is this in progress? please provide details  |   |
|  |  |
| **CONCURRENT DONOR VT / WUs**  |  |
|  |  |

|  |  |  |
| --- | --- | --- |
| 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  |
|  |
|  |  |  |
| **Samples** to be delivered to: |  |  |
|  |  |  |
| Name |   |
|  |  |  |
| Address |   |
|  |  |  |
|  |   |
|  |  |
|  |   |
|  |  |  |
|  |  |  |
| Contact Name |   |
|  |  |  |
| Phone Number |   |
|  |  |  |
| After Hours Number |   |
|  |  |  |
| Fax |   |
|  |  |  |
| Email |   |
|  |  |  |
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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)** |
|  |
|  |
| 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 |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |
|  |  |  |  |  |  |
| **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 |   | 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: |
|  |
|   |
|  |
| **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 |   |
|  |
| Name of clinical prescriber  |   | 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 |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |
| **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 |   |
|  |  |  |  |
| 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 COLLECTION** (maximum 100 ml) |
|  |
|   | ml EDTA |   | ml ACD | Other samplesPlease specify type/amount |   |
|  |  |  |  |  |  |
|   | ml Heparin |   | ml no anticoagulant |  |  |
|  |
|  |
| Name of clinical prescriber |   | Signature  |  | Date day/month/year |  |