Related Donor Workup Request

PATIENT DATA				
Patient name:				
Patient registry:				
Diagnosis:				
Patient ID: (assigned by patient registry)		Patient ID: (assigned by donor registry)		
Date of birth: (YYYY-MM-DD)	Gender:	Weight: (kg)	CMV:	ABO/Rh formula (Cc D. Ee):

RELATED DONOR DATA				
Full Donor Name:				
Relationship to patient:				
Address:				
City:	Country:		ZIP Code:	
E-mail:		Tel:		
Date of birth: (YYYY-MM-DD)	Gender:	Weight: (kg)	CMV:	ABO/Rh formula (Cc D. Ee):
Has the donor been informed that this request has been made?:	☐ Yes	☐ No		
Is the donor already registered with a donor center? If yes, which: If DKMS, please add Donor No.				

TRANSPLANT CENTER DATA			
Transplant Center Name:			
Contact person:			
Address:			
City:	Country:	ZIP Code:	
E-mail:	Tel:		
Emergency Number:			

PRODUCT SHIPPING ADDRESS:	INVOICE(S) TO BE SENT TO:
Institution:	Institution:
Address:	Address:
ZIP code:	ZIP code:
City:	City:
Country:	Country:
Attention:	Attention:
Phone:	Phone:
Fax:	Fax:
E-mail:	E-mail:

DKMS
WE DELETE BLOOD CANCER

Related Donor Workup Request

PATIENT DATA	
Patient name:	
Patient registry:	
Patient ID: (assigned by patient registry)	Patient ID: (assigned by donor registry)

RELATED DONOR DATA
Full Donor Name:
Date of birth (YYYY-MM-DD):

PRODUCT REQUEST	
☐ HPC, Marrow ONLY	☐ HPC, Marrow, second option: HPC, Apheresis
☐ HPC, Apheresis ONLY	☐ HPC, Apheresis, second option: HPC, Marrow
☐ MNC, Apheresis, please specify number of DLI (e.g. 1st, 2nd):	
Reason for product preference:	

DONOR PREFERENCE (in case of HPC, Marrow and/or HPC, Apheresis)		
Are any other donors under consideration for donation of behalf of this patient?	☐ Yes	☐ No
Are any other donors in process of physical examination on behalf of this patient?	☐ Yes	☐ No
If you have answered yes to either of these questions above, is this donor requested for stem cell collection on this form the preferred donor?	☐ Yes	☐ No
If no, please explain:		

PROTOCOL DATA please enclose a brief protocol flow chart if applicable
Products that are included in the protocol and therefore may later be requested: ☐ Additional HPC, Marrow ☐ Additional HPC, Apheresis ☐ MNC, Apheresis, specify number of DLI: ☐ Other, please specify:
Total days of conditioning regimen the patient will receive prior to infusion:
This includes chemotherapy for days, and radiation for days

TRANSPLANT HISTORY		
Has this patient received any previous stem cell transplants?	☐ Yes	☐ No
If yes, please include WMDA Form F20 and answer following transplant history questions: List types and dates of previous (allogenic) transplants: Specify source of stem cells: Reason for subsequent transplant:		
In case the current request is for an MNC apheresis answer the following transplant history questions: Did the donor being requested above previously donate stem cells on behalf of this patient? Was any of the original stem cell product cryopreserved for later infusion? If yes, was that product infused?	☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No

PREFERRED DATES (in order of preference)	
(First) collection date: (YYYY-MM-DD)	Corresponding infusion date: (YYYY-MM-DD)
1	1
2	2
3	3
Minimum number of days prior to collection that donor clearance must be received:	

Related Donor Workup Request

PATIENT DATA	
Patient name:	
Patient registry:	
Patient ID: (assigned by patient registry)	Patient ID: (assigned by donor registry)

RELATED DONOR DATA
Full Donor Name:
Date of birth (YYYY-MM-DD):

PICK UP PREFERENCE
Pick up preference, if one apheresis is sufficient: ☐ Pick up at the end of the first collection day ☐ No pick-up preference
Comments:

PRE-COLLECTION SAMPLES				
Are pre-collection samples required?	☐ Yes	☐ No		
Sample type:	ml heparin ml no anticoagulant	ml EDTA ml other:	ml ACD	

PRE-COLLECTION SAMPLES TO BE SHIPPED TO:	
Institution:	
Attention:	
Address:	
ZIP code:	
City:	Country:
Phone:	Fax:
Email:	

STEM CELL AND/OR LYMPHOCYTE COLLECTION	
Product type:	
Cell type:	
Required cells/kg	
x Patient weight (kg)	
= Total number of cells	
+ Cells for quality assurance testing	
= Total number of cells	
Please provide explanation for high number of cells:	Please provide explanation for high number of cells:
IRB/Ethics board approval (or equivalent): Date: (YYYY-MM-DD)	IRB/Ethics board approval (or equivalent): Date: (YYYY-MM-DD)

Related Donor Workup Request

PATIENT DATA	
Patient name:	
Patient registry:	
Patient ID: (assigned by patient registry)	Patient ID: (assigned by donor registry)

RELATED DONOR DATA
Full Donor Name:
Date of birth (YYYY-MM-DD):

ADDITIONAL SAMPLES TO ACCOMPANY STEM CELL OR LYMPHOCYTE PRODUCT

Peripheral blood samples:

ml heparin ml ACD ml EDTA ml no anticoagulant

ml product tube, type: ml other:

Samples to be taken on collection day:

Additional comments:

TRANSPORT DATA	
Product type:	Product type:
Required anticoagulant:	Required anticoagulant:
☐ Heparin ☐ EDTA ☐ ACD ☐ Other:	☐ Heparin ☐ EDTA ☐ ACD ☐ Other:
Donor plasma required? ☐ Yes ☐ No If yes, please indicate the desired final concentration:	Donor plasma required? ☐ Yes ☐ No If yes, please indicate the desired final concentration:
Transport temperature:	Transport temperature:
Preferred method of overnight storage of product(s) (if needed):	Preferred method of overnight storage of product(s) (if needed):
Additional instructions:	Additional instructions:
Should transport be organized by DKMS? ☐ Yes ☐ No	

REQUIRED DOCUMENTATION TO ACCOMPANY THIS REQUEST

In case of HPC, Marrow and/or HPC, Apheresis:

WMDA Form F30 Final Compatibility Test Results, or equivalent

DISCLAIMER:

- The cell products collected from this donor are intended solely for the purpose of immediate therapeutic treatment for the above-mentioned patient. Any planned cryopreservation of the cell products prior to initial infusion to the patient may only occur with the advance written informed consent of the related donor and the written approval from the responsible donor center (DKMS).
- Excess cells may be stored for future therapeutic treatment for this patient. No other uses of these cells are permissible. Cells not used for the therapeutic treatment of the above-mentioned patient must be disposed of properly and details must be provided to the responsible donor center.
- By accepting these cells, the transplant physician also accepts these terms and conditions. Deviations from these terms are not permitted without prior written approval from the responsible donor center.
- Transplant Centers: Any serious product or recipient events and/or adverse reactions must be reported to the responsible donor center.
- DKMS: Corresponding S(P)EAR reports must be completed by the responsible donor center or transplant center and submitted to the WMDA office via the affiliated registry. Both sides need to align who will submit the results.

Person completing form:	Date: (YYYY-MM-DD)	Signature: