Bone Marrow Donation

Welsh Bone Marrow Donor Registry (WBMDR)

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FORMAL REQUEST FOR HUMAN PERIPHERAL BLOOD LYMPHOCYTE COLLECTION

(Following previous stem cell transplants only)

PATIENT DATA:

Patient name:		Patient ID number: (assigned by patient's registry)		
Patient registry:		Patient ID number: (assigned by donor's registry)		
Diagnosis:		Current disease status:		
Date of birth: (Day/Month/Year)	Gender:	Weight: **kg**	CMV:	Blood Group:

TRANSPLANT CENTRE:

Hospital:	Contact name:
Address:	Phone no:
	Fax no:
	Email:

DONOR DATA:

Donor ID number:		GRID:		
Donor's Registry: **WBMDR**				
Age or date of birth: (Day/Month/Year)	Gender:	Weight: **kg**	CMV:	Blood Group:

PRODUCT REQUEST:

DLI: 1st ☐ 2nd ☐ 3rd ☐ >3rd ☐ If >3rd DLI, indicate no. of DLI:

PROTOCOL DATA (A *brief* protocol flow chart must be enclosed):

Products that are *included* in the protocol and therefore may later be requested:
One DLI ☐ >1 DLIs ☐ (Number:____) Additional BM ☐ Additional PBSC ☐
Other ☐ (Please specify):

2nd transplant ☐ >2nd transplant ☐ If >2nd transplant, list types & dates of previous transplants:
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? _____ Infused? _____

PREFERRED DATES (in order of preference):

	Collection Date		Corresponding Infusion Date
1		1	
2		2	
3		3	

Minimum number of days prior to collection that donor clearance must be received: _____

REQUIRED DOCUMENTATION TO ACCOMPANY THIS REQUEST

1. Detailed description of patient's post-transplantation condition.
2. Summary of transplant protocol to be used with the most recent protocol review date.
3. Completed Prescription for Peripheral Blood Lymphocyte Collection form.

Person Completing Form:	Signature:	Date: (Day/Month/Year)