Bone Marrow Donation

Welsh Bone Marrow Donor Registry (WBMDR)

Welsh Transplantation & Immunogenetics Laboratory, Welsh Blood Service, Pontyclun CF72 9WB, Wales, U.K.
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PREVIOUS TRANSPLANT HISTORY and FORMAL REQUEST for SUBSEQUENT STEM CELL COLLECTION

(To be submitted with formal request for subsequent stem cell collections)

PATIENT DATA:

Patient name:		Patient ID number: (assigned by patient's registry)		
Patient registry:		Patient ID number: (assigned by donor's registry)		
Pre-transplant diagnosis:		Disease status at time of initial transplant:		
Date of birth: (Day/Month/Year)	Gender:	Weight (kg): **kg**	CMV:	Blood Group / Rh:
Current disease status:				
Reason for subsequent donation request:				

DONOR DATA: Information on currently requested donor

Donor ID number:		GRID:		
Donor's Registry: **WBMDR**				
Age or date of birth: (day/month/year)	Gender:	Weight: **kg**	CMV:	Blood Group / Rh:

DATA FROM PREVIOUS TRANSPLANT:

Number of previous transplants:		
Date of last stem cell infusion: ____ / ____ / ____ (day/month/year)	Manipulation: (state type e.g. T-cell depletion, plasma removal etc.)	
Source of stem cells for last transplant: ☐ Allogeneic Marrow ☐ Allogeneic PBSC ☐ Cord Blood ☐ Autologous ☐ Related ☐ Unrelated In case of unrelated: donor ID, source of stem cells, date of donation:		
Cell dose administered to recipient:	MARROW x 10^8 / kg (MNC)	PBSC x 10^6 / kg (CD34+)
Details on conditioning treatment:	Myeloablative dose-reduced Did the conditioning regimen include TBI? ☐ YES ☐ NO	
GvHD prophylaxis administered:		

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DETAILS of PREVIOUS TRANSPLANT HISTORY

DATA FROM PREVIOUS TRANSPLANT (continued):

Was any portion of the stem cell product frozen?	☐ YES ☐ NO If YES, list the cell dose available: Reason for freezing:	
	MARROW x 10^8 / kg (MNC)	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 date: _____ / _____ / _____ (Day/Month/Year)	

ENGRAFTMENT DATA / DISEASE STATUS

Engraftment: ☐ YES ☐ NO Date (neutrophils > 0.5 x 10^9/L) ____ / ____ / _____ (Day/Month/Year)
In case of allogeneic SCT hematopoietic chimerism (most recent result with date): ☐ Donor ☐ Mixed ☐ Recipient ☐ Not performed Date: ____ / ____ / __ Please state percentage: donor ______% recipient ________% (Day/Month/Year)
Best response of disease to transplant: Date achieved: ____ / ____ / _____ (Day/Month/Year) Evaluated by: Current disease status: Date of assessment: ____ / ____ / _____ (Day/Month/Year)
Chromosome/PCR data (state source – marrow or blood) on disease and chimerism Most recent result with date: Evaluated by:
Additional comments:

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TRANSPLANT RELATED COMPLICATIONS IN PATIENT:

GVHD: (Grade/organs involved and treatment received)
Acute yes/no Grade Resolved yes/no
Chronic yes/no Grade Resolved yes/no

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 medication**:** (please list)

Describe any intensive medical support the recipient is receiving e.g. Ventilation, dialysis etc:

CURRENT RECIPIENT CONDITION (Laboratory Data):

(blanks are considered to represent normal results)

WBC:	WBC Differential:	
	Neutrophils	Blasts
	Lymphocytes	Others

Hemoglobin _______g/dL Frequency of red blood cell transfusions: ____________________

Date of last red cell transfusion: ____ / ____ / ___
(Day/Month/Year)

Platelets _________x 10^9/L Frequency of **platelet** transfusions: ______________________

Date of last platelet transfusion: ____ / ____ / ____
(Day/Month/Year)

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CURRENT RECIPIENT CONDITION (continued):

Please give the following results only if abnormal:			
Urea:	mg/dL	AST:	U/L
Creatinine:	mg/dL	Alkaline Phosphatase:	U/L
Bilirubin:	mg/dL	Chest X-Ray:	

PREVIOUS REQUESTS FOR SUBSEQUENT DONATION:

Has there been a previous post transplant donation request for this donor? ☐ YES ☐ NO

If yes, was the request approved? ☐ YES ☐ NO

If the request was refused, state why:

Product requested

DETAILS ON PLANNED NEW SCT:

Planned recipient treatment: (with dates):

No. of days of conditioning prior to stem cell infusion:

Preferred harvest date:

Alternative dates:

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

Is product manipulation planned?: ☐ YES ☐ NO

If YES, briefly describe the planned manipulation:

Prophylaxis for GVHD:

<u>Treatment alternative for patient besides URD</u>

Is a backup marrow/PBSC or frozen marrow/PBSC available? ☐ YES ☐ 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:

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DETAILS of PREVIOUS TRANSPLANT HISTORY

PRODUCT REQUEST:

Product preference: ☐ Bone Marrow (BM) ☐ Lymphocyte (unstimulated leukopheresis)

☐ Stimulated PBSC ☐ Unit of whole blood

Please fill in a numeric value next to products to indicate preference:

1=1st preference; **2**=2nd preference; **0**=not desired if 1st preference not possible

REASON FOR PRODUCT PREFERENCE: Please provide relevant information

REQUIRED DOCUMENTATION TO ACCOMPANY THIS REQUEST

1. Formal Request for Human Stem Cell Collection or Formal Request for Human Peripheral Blood Lymphocyte form.
2. Copy of all laboratory reports listing HLA typing results of patient and donor.
3. Completed Marrow, PBSC or Unstimulated Leukopheresis Prescription Form(s)
   A prescription form is not required for a unit of blood

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