F60 DONOR FINAL CLEARANCE PRE-STEM CELL COLLECTION

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

DONOR DATA			
Donor ID:			
GRID number:			
Donor registry:			
Date of birth: (YYYY-MM-DD)	Gender:	Weight:(kg)	Blood group/RhD:
Transfusions:	Number:	Pregnancies:	Number:

TEST DATA (1/2)					
Test:		Positive:	Negative:	Not tested:	Date tested: (YYYY-MM-DD)
Hepatitis B Virus (HBV)					
HBs Ag (surface antigen screening test)		☐	☐	☐	
Anti-HBc (antibody screening test)		☐	☐	☐	
HBV-NAT (Nucleic Acid Amplification Technique)		☐	☐	☐	
Hepatitis C Virus (HCV)					
Anti-HCV (antibody screening test)		☐	☐	☐	
HCV (RIBA verification test)		☐	☐	☐	
HCV-NAT		☐	☐	☐	
Human T-Lymphotropic Viruses (HTLV)					
Anti-HTLV I/II (screening test)		☐	☐	☐	
Human Immunodeficiency Virus (HIV)					
HIV-1 p24 antigen (screening test)		☐	☐	☐	
HIV-NAT		☐	☐	☐	
Anti-HIV 1 and Anti-HIV 2 (antibody screening test)		☐	☐	☐	
Syphilis					
STS (serological test for syphilis)		☐	☐	☐	
Other					
CMV (Cytomegalovirus) antibodies	IgG	☐	☐	☐	
	IgM	☐	☐	☐	
	total	☐	☐	☐	
WNV-NAT testing (West Nile Virus)		☐	☐	☐	
EBV (Epstein Barr Virus) antibodies	IgM	☐	☐	☐	
	IgG	☐	☐	☐	

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Patient ID: (assigned by patient registry)	Patient ID: (assigned by donor registry)

DONOR DATA
Donor ID:
GRID number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐
Donor registry:

TEST DATA (2/2)

Test:		Positive:	Negative:	Not tested:	Date tested: (YYYY-MM-DD)
Toxoplasmosis antibodies	IgG	☐	☐	☐	
	IgM	☐	☐	☐	
	total	☐	☐	☐	
		normal:	elevated:	not tested:	
ALT (Alanine Aminotransferase)		☐	☐	☐	
Other(s), please specify:					

VERIFICATION TEST DATA

Test:	Positive:	Negative:	Not tested:	Date tested: (YYYY-MM-DD)
HBs Ag neutralization (surface antigen verification test)	☐	☐	☐	
Anti-HTLV I/II (verification test. 2nd test performed with a different kit)	☐	☐	☐	
HIV 1 p24 antigen neutralization (verification test)	☐	☐	☐	
Anti-HIV 1 by Western Blot (verification test)	☐	☐	☐	
Anti-HIV 2 by Immunoblot (verification test)	☐	☐	☐	
FTA-ABS (verification test)	☐	☐	☐	
Other(s), please specify:				

Informed consent signed? ☐ Yes ☐ No	Date: (YYYY-MM-DD)	
Collection date(s): (YYYY-MM-DD)		Start date G-CSF:
Medical clearance provided? ☐ Yes ☐ No	Date: (YYYY-MM-DD)	
If final clearance for donation is not granted, please detail reason(s):		
Additional comments:		

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

DONOR DATA
Donor ID:
GRID number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐
Donor registry:

Donor/collection center representative:	Date: (YYYY-MM-DD)	Donor/collection center signature:
Reviewer checking this form:	Date: (YYYY-MM-DD)	Reviewer signature:

TRANSPLANT CENTER ACCEPTANCE OF DONOR FINAL CLEARANCE		
I have received and reviewed the pre-collection physical examination test results and/or summaries from the lead collection physician for this donor.		
☐ I find that this volunteer stem cell donor is an acceptable donor for stem cell collection. Patient consent for the donation has been verified. Scheduled transplantation date: (YYYY-MM-DD) Start date preparation of the patient: (YYYY-MM-DD) ☐ I do not require further testing or information at this time. ☐ Based on the results provided, additional testing must be performed or additional information provided before stem cell collection can occur. Please provide additional comments below.		
Comments:		
Transplant center representative:	Date: (YYYY-MM-DD)	Transplant center signature: