DF1 DONOR ASSESSMENT POST STEM CELL DONATION

(To be completed by the donor center by phone or by the donor the **WEEK** following donation)

DONOR DATA	
Donor name:	
Donor ID:	Date of birth: (YYYY-MM-DD)
GRID number:	

DONATION DATA		
Hospital/Apheresis center:	City:	
Physician name:	Date(s) of stem cell collection: (YYYY-MM-DD)	
Type of donation:	☐ Bone marrow ☐ PBSC	
	☐ 1st donation ☐ 2nd donation	

DONOR EXPERIENCE				
How do you feel physically?	☐ better than usual	☐ normal	☐ worse than usual	☐ much worse than usual
How do you feel emotionally?	☐ better than usual	☐ normal	☐ worse than usual	☐ much worse than usual

After donation did you experience any of the following?

☐ tiredness	☐ insomnia	☐ fever	☐ sore throat
☐ headache	☐ vertigo	☐ bone pain	☐ pain at the site of donation
☐ night sweats	☐ stiffness	☐ nausea/vomiting	
☐ rashes	☐ loss of appetite		

Other, please specify:

Do you feel you were correctly informed and obtained a clear idea about the stem cell donation you have recently done? ☐ Yes ☐ No

Please specify:

AT THE HOSPITAL/APHERESIS CENTER

Do you feel that the staff adequately supported you through the donation? ☐ Yes ☐ No

Please specify:

Do you feel you were well cared for by the hospital staff? ☐ Yes ☐ No

Please specify:

If no, please indicate how the staff could have provided greater assistance:

Did you encounter any particular problem related to your donation? ☐ Yes ☐ No

Please specify:

Is there anything that could have been done to make the donation a better experience for you? Or do you have any suggestions as how we can improve the care of future donors?

Before donation:

After donation:

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

WMDA