F10 FORMAL REQUEST FOR HPC,MARROW; HPC, APHERESIS OR MNC, APHERESIS

PATIENT DATA				
Patient name:				
Patient registry:				
Diagnosis:				
Patient ID: (assigned by patient registry)		Patient ID: (assigned by donor registry)		
Transplant center:				
Date of birth: (YYYY-MM-DD)	Gender:	Weight: (kg)	CMV:	Blood group/RhD:

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

Shipping address:	**Invoice(s)** to be sent to: Copy shipping address
Institution:	Institution:
Address:	Address:
ZIP code:	ZIP code:
City:	City:
Country:	Country:
Attention:	Attention:
Phone:	Phone:
Fax:	Fax:
E-mail:	E-mail:

PRODUCT REQUEST

- ☐ HPC, Marrow ONLY
- ☐ HPC, Apheresis ONLY
- ☐ MNC, Apheresis, please specify number of DLI (e.g. 1st, 2nd):
- ☐ HPC, Marrow, second option: HPC, Apheresis
- ☐ HPC, Apheresis, second option: HPC, Marrow

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:

WMDA

Reset Form

F10 FORMAL REQUEST FOR STEM CELL OR LYMPHOCYTE COLLECTION

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

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

PROTOCOL DATA please enclose a brief protocol flow chart

Products that are included in the protocol and therefore may later be requested:

☐ Additional HPC, Marrow ☐ Additional HPC, Apheresis ☐ MNC, Apheresis, please specify number of DLI:

☐ Other, please specify:

PROTOCOL DATA (continued)

Total number of days of conditioning regimen:

Number of days of chemotherapy the patient will receive prior to infusion:

Number of days of radiation the patient will receive prior to infusion:

These questions are only to be answered in case of MNC, Apheresis:

Please list types and dates of any previous (allogenic) transplants:

Did the donor being requested above previously donate stem cells on behalf of this patient?	☐ Yes	☐ No
Was any of the original stem cell product cryopreserved for later infusion?	☐ Yes	☐ No
If yes, was that product infused?	☐ Yes	☐ No

TRANSPLANT HISTORY (in case of HPC, Marrow and/or HPC, Apheresis and/or HPC Cord)

Has this patient received any previous stem cell transplants? ☐ Yes ☐ No

If YES, specify source of stem cells AND specify reason for subsequent transplant:

Reason for subsequent transplant:

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:	

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:

F10 FORMAL REQUEST FOR STEM CELL OR LYMPHOCYTE COLLECTION

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

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

REQUIRED DOCUMENTATION TO ACCOMPANY THIS REQUEST

In case of HPC, Marrow and/or HPC, Apheresis:
1. WMDA Form F30 Final Compatibility Test Results, or equivalent
2. WMDA Form F40 Prescription, or equivalent

In case of MNC, Apheresis:
1. Summary of transplant protocol to be used with the most recent protocol review date
2. WMDA Form F20 Transplant History, or equivalent
3. WMDA Form F40 Prescription, or equivalent

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