

F80

NOTIFICATION OF DONOR CLEARANCE

Page 1 of 3

<input type="radio"/> HPC, Marrow	<input type="radio"/> HPC, Apheresis	<input type="radio"/> MNC, Apheresis
If final clearance for donation is NOT granted, please complete form C30 instead.		

SECTION A: TO BE COMPLETED BY THE APHERESIS/COLLECTION CENTRE

PATIENT DATA	
Patient first name:	Patient last name:
Patient registry:	
Date of birth: (YYYY-MM-DD)	
Patient ID: (assigned by patient registry)	Patient ID: (assigned by donor registry)

DONOR DATA				
Donor registry:	ION:			
Donor ID:				
GRID:				
Date of birth: (YYYY-MM-DD)	Gender:	Weight:(kg)	CMV:	Blood group/RhD:
Transfusions:	Number(s)/year(s):	Pregnancies:	Number(s):	
Irregular antibodies:				

COLLECTION DATE INFORMATION	
Donor informed consent signed on: (YYYY-MM-DD)	Donor clearance confirmed on: (YYYY-MM-DD)
First date of donor G-CSF injections: (YYYY-MM-DD)	Confirmed first collection date: (YYYY-MM-DD)

TEST DATA (1/2)				
Donor Infectious Disease Test Results	Positive	Negative	Not tested	Date of blood collection: (YYYY-MM-DD)
Hepatitis B Virus (HBV)				
HBsAg (Hepatitis B surface antigen screening test)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Anti-HBc (Hepatitis B core antibody)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
HBV-NAT (Nucleic Acid Amplification Technique)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Hepatitis C Virus (HCV)				
Anti-HCV (Hepatitis C antibody screening test)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
HCV-PCR (PCR Hepatitis C virus test)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
HCV-NAT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Human T-Lymphotropic Viruses (HTLV)				
Anti-HTLV I / II (antibodies to human T-lymphotropic virus I / II screening test)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Human Immunodeficiency Virus (HIV)				
HIV-1 p24 antigen (screening test)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
HIV-NAT (Nucleic Acid Amplification Technique)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Anti-HIV 1/2 (antibodies to HIV 1/2 screening test)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

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PATIENT DATA	
Patient first name:	Patient last name:
Patient registry:	
Date of birth: (YYYY-MM-DD)	
Patient ID: <small>(assigned by patient registry)</small>	Patient ID: <small>(assigned by donor registry)</small>

DONOR DATA	
Donor registry:	ION:
Donor ID:	
GRID:	

TEST DATA (2/2)				
Donor Infectious Disease Test Results	Positive	Negative	Not tested	Date of blood collection: <small>(YYYY-MM-DD)</small>
Syphilis				
STS (serologic test for syphilis)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Other				
CMV (Cytomegalovirus) antibodies IgG	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
IgM	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
total	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
WNV-NAT (West Nile Virus)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
EBV (Epstein Barr Virus) antibodies IgG	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
IgM	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Toxoplasmosis antibodies IgG	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
IgM	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
total	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	normal	Elevated	Not tested	
ALT (Alanine Aminotransferase)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Verification test(s), if performed:				
Other tests (please specify):				

ADDITIONAL DONOR INFORMATION (1/2)
Comments/attachments:
Based on the results of the donor history, examination and test the donor has:
<input type="radio"/> no medical problems. Which would make him/her suitable for the donation.
<input type="radio"/> medical problems. Which would make him/her unsuitable for the donation.
The donor is in good health and a fit candidate for _____ donation.

F80

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Page 3 of 3

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PATIENT DATA	
Patient first name:	Patient last name:
Patient registry:	
Date of birth: (YYYY-MM-DD)	
Patient ID: <small>(assigned by patient registry)</small>	Patient ID: <small>(assigned by donor registry)</small>

DONOR DATA	
Donor registry:	ION:
Donor ID:	
GRID:	

ADDITIONAL DONOR INFORMATION (2/2)		
Name of collection/apheresis centre:		
Donor/collection centre representative:	Date: (YYYY-MM-DD)	Donor/collection centre signature:
Reviewer checking this form:	Date: (YYYY-MM-DD)	Reviewer signature:

SECTION B: TO BE COMPLETED BY THE TRANSPLANT CENTER

TRANSPLANT CENTRE ACCEPTANCE OF DONOR FINAL CLEARANCE		
I have received and reviewed the pre-collection physical examination test results for this donor.		
<input type="radio"/> I do not require further testing or information at this time.		
<input type="radio"/> I need additional information or testing. Please provide additional comments below.		
<input type="radio"/> I find this donor acceptable for stem cell donation. Patient consent for the donation has been verified.		
Patient consent for the transplantation has been verified.		
First day of patient conditioning regimen: (YYYY-MM-DD)		
First collection date: (YYYY-MM-DD)		
Date of transplant: (YYYY-MM-DD)		
Comments:		
Transplant centre contact person(s):		
Telephone number:		
24-hour telephone number:		
Transplant centre representative:	Date: (YYYY-MM-DD)	Transplant centre signature: