



佛教慈濟骨髓幹細胞中心
Buddhist Tzu Chi Stem Cells Center
Work-up Request Form

General Information

Date :

Recipient BTCSCC ID :

Donor BTCSCC ID :

Recipient Name :

Recipient ID Number :

Activating work-up request? Yes No

Has the patient undergone a previous stem cell transplant? No Yes → Indicate
Type of transplant and date performed _____

Preferred stem cell Bone Marrow PBSC Lymphocyte Others _____

Proposed collection date(s)

First Choice _____ Second Choice _____ Third Choice _____

●How many days is this patient's preparative regimen? _____ Days

●What is the latest date the transplant center needs to receive donor clearance in order to meet the first choice collection date(s)? _____

●Day(s) of the week transplant center prefers a stem cell product(s) collected :

Monday Tuesday Wednesday Thursday Friday

Patient Clinical Condition

(Provide relevant information that can assist in the counselling of the potential donor.)

1. Blood type _____ Weight _____ kg Height _____ cm

2. Patient current diagnosis & disease stage __ (Please fill out Page. 2.) __

3. The patient's preparative regimen will be Myeloablative Reduced Intensity
List drugs and/ or TBI schedule _____

4. Excluding plasma/ red cell depletion, the stem cell product will be

Un-manipulated T-cell depleted CD34+ selected Other _____

5. Classify workup based on patient clinical condition Urgent Standard
Transplant Center _____

Referring Physician Signature _____

Name in Print _____ Date ____ / ____ / ____ (yyyy/mm/dd)

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Tel : +886-3-8561825 Ext : 3518/3519/3216 Fax : +886-3-8572614, +886-3-8574324

707 Sec. 3, Chung Yang Road, Hualien, Taiwan 970, R.O.C.



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Recipient BTCSCC ID :	Donor BTCSCC ID :
Recipient Name :	Recipient ID Number :

Patient Current Diagnosis and Disease Stage	
<input type="checkbox"/> ALL	<input type="checkbox"/> with Philadelphia <input type="checkbox"/> without Philadelphia <input type="checkbox"/> CR1 <input type="checkbox"/> CR2 <input type="checkbox"/> \geq CR3 <input type="checkbox"/> Not in CR ___% of blast cells in BM
<input type="checkbox"/> AML	<input type="checkbox"/> <i>de novo</i> AML except APL <input type="checkbox"/> <i>de novo</i> APL <input type="checkbox"/> Secondary AML Specify original disease _____ <input type="checkbox"/> CR1 <input type="checkbox"/> CR2 <input type="checkbox"/> \geq CR3 <input type="checkbox"/> Not in CR ___% of blast cells in BM
<input type="checkbox"/> CML	<input type="checkbox"/> Chronic Phase <input type="checkbox"/> Accelerated Phase <input type="checkbox"/> Blast Crisis
<input type="checkbox"/> Other Leukemia Specify _____	<input type="checkbox"/> CR <input type="checkbox"/> Not in CR
<input type="checkbox"/> Hodgkin's Lymphoma	<input type="checkbox"/> CR <input type="checkbox"/> Not in CR
<input type="checkbox"/> Non-Hodgkin's Lymphoma	<input type="checkbox"/> CR <input type="checkbox"/> Not in CR
<input type="checkbox"/> Plasma Cell Disorder Multiple Myeloma <input type="checkbox"/> Other Plasma Cell Disorder Specify _____	
<input type="checkbox"/> Other Cancer Not in Above Specify _____ <input type="checkbox"/> CR <input type="checkbox"/> Not in CR	
<input type="checkbox"/> Myelodysplasia(MDS) / Myeloproliferative Disorder(MPD) Specify _____	
<input type="checkbox"/> Defective Hemopoiesis	<input type="checkbox"/> Aplastic anemia <input type="checkbox"/> Thalassemia <input type="checkbox"/> Other, specify _____
<input type="checkbox"/> Immune Deficiency Disorder Specify _____	
<input type="checkbox"/> Metabolic Storage Disease Specify _____	
<input type="checkbox"/> Histiocytic Disorders Specify _____	
<input type="checkbox"/> Other Disease Not in Above Specify _____	

BTCSCC Medical Director Approval _____ Date ____ / ____ / ____ (yyyy/mm/dd)

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