F20

PREVIOUS TRANSPLANT HISTORY

PATIENT DATA				
Patient first name:	Patient last name:			
Patient registry:				
Patient ID: (assigned by patient registry)	Patient ID: (assigned by donor registry)			
Transplant centre:				
Pre-transplant diagnosis:				
Disease status at time of initial transplant:				
Date of birth: (YYYY-MM-DD)	Gender:	Weight:(kg)	CMV:	Blood group/RhD:
Current disease status:				
Reason for subsequent donation request:				

DONOR DATA Information on currently requested donor	
Donor registry:	ION:
Donor ID:	
GRID:	

DATA FROM PREVIOUS TRANSPLANT			
Number of previous infusions:		Date of last stem cell infusion: (YYYY-MM-DD)	
Manipulation		Other:	
Source of stem cells for last infusion:	◯ Allogeneic marrow ◯ Autologous	◯ Allogeneic PBSC ◯ Related	◯ Cord Blood ◯ Unrelated
Cell dose administered to recipient:	Marrow: x 10^8/kg (MNC)	PBSC: x 10^6/kg (CD34+)	
Details on conditioning treatment:	◯ Myeloablativ	◯ Non-myeloablative	
Did the conditioning regimen include TBI?	◯ Yes	◯ No	
GvHD prophylaxis administered:	◯ Yes ◯ No	If yes, state name of agent:	
Was any portion of the stem cell product cryopreserved?	◯ Yes ◯ No	Reason for cryopreservation:	
If Yes, list the cell dose available:	Marrow: x 10^8/kg (MNC)	PBSC: x 10^6/kg (CD34+)	
If any portion of the stem cell product was cryopreserved, was it infused? ◯ Yes ◯ No If Yes, what was the date of infusion? (YYYY-MM-DD) Reason for infusion:			
Are autologous rescue cells available?	◯ Yes ◯ No		
Alternative treatment for patient besides URD: Is there an alternative suitable unrelated donor? Is there an alternative suitable unrelated cord blood unit?	◯ Yes ◯ No ◯ Yes ◯ No		

ENGRAFTMENT DATA/DISEASE STATUS					
Engraftment:	◯ Yes ◯ No	Date neutrophils > 0.5 x 10^9/L: (YYYY-MM-DD)			
Chimerism results:	◯ Donor ◯ Mixed	◯ Recipient	◯ Not performed	Date: (YYYY-MM-DD)	
If mixed, please state percentage:	% donor and	% recipient			
Best response of disease to transplant:				Date achieved: (YYYY-MM-DD)	

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DONOR DATA Information on currently requested donor	
Donor registry:	ION:
Donor ID:	
GRID:	

TRANSPLANT RELATED COMPLICATIONS IN PATIENT

GvHD: (grade/organs involved and treatment received) Acute: Grade: Resolved:
Chronic: Grade: Resolved:

Did the patient suffer from any serious infections? ◯Yes ◯No If yes, please specify:
Resolved: ◯Yes ◯No Additional information:

Did the patient suffer of organ toxicity? ◯Yes ◯No If yes, please specify:
Resolved: ◯Yes ◯No

CURRENT CLINICAL STATUS OF PATIENT

The clinical condition of the patient is: ◯Excellent ◯Good ◯Deteriorated

Is the patient in need of any intensive medical support? ◯Yes ◯No
If yes, please check all that apply: ☐Ventilator ☐Dialysis ☐Other:

Is the patient receiving any of the following medication? Please check all that apply:
☐ Hematopoietic growth factors ☐ Immunosuppressive ☐ Antibiotics ☐ Other:

CURRENT PATIENT CONDITION (Laboratory data)

Hemoglobin: Is the patient red cell transfusion dependent? ◯Yes ◯No
If yes, date last transfusion: (YYYY-MM-DD)

Platelets: x 10^9/L Is the patient platelet transfusion dependent? ◯Yes ◯No
If yes, date last transfusion: (YYYY-MM-DD)

Leukocyte count: x 10^9/L Test date: (YYYY-MM-DD)

Is the patient suffering from liver function abnormalities? ◯Yes ◯No
If yes, please add relevant laboratory findings:

Is the patient suffering from kidney function abnormalities? ◯Yes ◯No
If yes, please add relevant laboratory findings:

PREVIOUS REQUESTS FOR SUBSEQUENT DONATION

Has there been a previous post transplant donation request for this donor? ◯Yes ◯No

What product was requested? ◯Bone marrow ◯PBSC ◯Donor Lymphocytes

Was the request approved? ◯Yes ◯No
If the request was refused, please state why:

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PREVIOUS TRANSPLANT HISTORY

PATIENT DATA	
Patient first name:	Patient last name:
Patient registry:	
Transplant centre:	
Patient ID: (assigned by patient registry)	Patient ID: (assigned by donor registry)

DONOR DATA Information on currently requested donor	
Donor registry:	ION:
Donor ID:	
GRID:	

DETAILS PLANNED ON NEW SCT	
Will the patient receive further conditioning prior to infusion? ◯Yes ◯No	
◯Myeloablativ ◯Non-myeloablative	Will the conditioning regimen include TBI? ◯Yes ◯No
Is product manipulation planned? ◯Yes ◯No	If yes, please specify:
Will prophylaxis for GvHD be given? ◯Yes ◯No	
Please state the expected response probability for your patient and describe the evidence for your expectation:	

PRODUCT PREFERENCE	
choose product preference	Reason for product preference:

This form is required for any formal request for subsequent donation.		
Person completing form:	Date: (YYYY-MM-DD)	Signature:

WMDA

Reset Form