



佛教慈濟骨髓幹細胞中心
Buddhist Tzu Chi Stem Cells Center
Preliminary Search Request

BTCSCC ID: _____ (assigned by BTCSCC) **Date of Request:** ____ / ____ / ____ (yyyy/mm/dd)

Type of Search to be performed: <input type="checkbox"/> Stem Cell Donor Only <input type="checkbox"/> Cord Blood Only <input type="checkbox"/> Stem Cell Donor & Cord Blood		Are mismatches accepted? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, specify locus/loci <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> DR	
Last Name:		First Name:	
Date of Birth (yyyy/mm/dd):	National ID (Taiwan Patient Only)	Your Patient ID	
Address (Taiwan Patient Only)			
TEL (Taiwan patient Only)	Mobile Phone (Taiwan patient Only)	FAX or E-Mail (Taiwan patient Only)	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Weight kg	Hight cm	Blood Type (Rh)
Diagnosis		Date of Diagnosis (yyyy/mm/dd)	
Latest Blood Transfusion: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify the transfusion date and type:			WBC: *10 ³ /ul
Transplanted: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify the date and type:			
Race <input type="checkbox"/> Native North American <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Unknown <input type="checkbox"/> Other			

Patient HLA Typing & Transplant Information

A		B		C	
<input type="checkbox"/> Serology	<input type="checkbox"/> HLA/DNA	<input type="checkbox"/> Serology	<input type="checkbox"/> HLA/DNA	<input type="checkbox"/> Serology	<input type="checkbox"/> HLA/DNA
DRB1		DQB1		Other, Specify	
<input type="checkbox"/> Serology	<input type="checkbox"/> HLA/DNA	<input type="checkbox"/> Serology	<input type="checkbox"/> HLA/DNA	<input type="checkbox"/> Serology	<input type="checkbox"/> HLA/DNA
Preferred Stem Cell: <input type="checkbox"/> Bone Marrow <input type="checkbox"/> PBSC <input type="checkbox"/> Cord Blood					
Preferred Transplant Date: 1. _____ 2. _____					
Transplant Hub:					
Transplant Center:					
Physician:			Coordinator:		
Coordinator E-Mail:					
TEL:			FAX:		

970 花蓮市中央路三段 707 號 E-mail : btcsc@tzuchi.com.tw
Tel : 886-3-8561825 Ext : 13518/13519/13216 Fax : 886-3-8570056/886-3-8572614
707 Sec. 3, Chung Yang Road, Hualien, Taiwan 970, R.O.C.



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