

Italian Bone Marrow Donor Registry
Form RC301-r (VI 1/1 Feb. 2010)

n° : _____ Date: ___/___/___



*Search re-activation
request*

Patient data:

Last name:.....First name:.....

Gender: M F Race*: C O N Date of birth
 * C = Caucasian A = Asian B = Black mm/dd/yyyy

If age > 65 years,
IRB approved protocol required

Registry/Institution in charge of the payment:.....

Address:.....

City:.....Zip Code:.....Country:.....

Diagnosis:

Date of primary diagnosis:(mm/dd/yyyy)

- | | |
|----------------------------------|-------------------------------|
| Fanconi's Anemia | Lymphoblastic lymphoma |
| ALL 1 st CR high risk | LNH |
| ALL 2 nd CR | CLL |
| AML 1 st CR high risk | Multiple Myeloma |
| AML 2 nd CR | SAA |
| AML 3 rd CR | Inborn errors (Specify):..... |
| CML 1 st CP | Hodgkin Lymphoma |
| Myelofibrosis | Neuroblastoma |
| MDS high risk | Other (Specify):..... |

Source of HSC * (Please fill in a numeric value next to the products to indicate preference):

- Bone Marrow PBSC HPC-Cord Blood Unit Not stimulated Lymphocytes

(Patient's weight)

..... Kg.

*1 First preference 2 Second preference 0 Not desiderated

Transplant Center:

TC Code:

Referring physician:

Signature:Date:.....