

n° : _____ Date: ___/___/___



*Previous transplant history and
Formal request for
subsequent stem cell collection*

To be completed by the transplant center

PATIENT DATA:

Patient name:	IBMDR Patient ID number:
Date of birth:..... (mm/dd/yyyy)	Pre-transplant diagnosis:
Disease status at time of initial transplant:	
Reason for the request: relapse no engraftment Other, specify:	

TRANSPLANT CENTER:

IBMDR TC code:	Contact person:
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REQUESTED DONOR DATA:

Donor ID code:

PRODUCT REQUEST:

..... Not stimulated peripheral blood lymphocyte Bone Marrow Stimulated PBSC
Please fill in a numeric value next to both products to indicate preference
1= 1st preference 2=2nd preference; 0= not desired if 1st preference not possible

PREFERRED COLLECTION DATE (mm/dd/yyyy):

Bone Marrow collection*	PBSC* collection Indicate the first day's collection	Not stimulated lymphocytoapheresis:
1	1	1
2	2	2
3	3	3

The donor clearance must be received before:(mm/dd/yyyy)

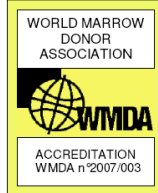
*Number of days of conditioning prior to transplant:

(Conditioning of patient must not be undertaken until the registry has confirmed the donor to be medically fit and the results of all screening tests are known and have been reported to, and accepted by, the transplant center).

DATA FROM PREVIOUS TRANSPLANT:

Number of previous transplant:		
Date of last stem cell infusion:(mm/dd/yyyy)	Manipulation: (state type e.g. : T cell depletion, plasma removal etc.)	
Source of stem cells for last transplant:		
Bone Marrow	Stimulated PBSC	Cord Blood
Cell dose administered to recipient:	MARROW x 10 ⁸ / kg (MNC)	PBSC x 10 ⁶ / kg (CD34+)
Details on conditioning treatment:	Myeloablative	Dose-reduced
	Did the conditioning regimen include TBI?	YES NO
GvHD prophylaxis administered:		

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.....

ENGRAFTMENT DATA / DISEASE STATUS

Engraftment: YES	NO	Date (neutrophils > 0.5 x 10 ⁹ /L):	(mm/dd/yyyy)
Chimerism (most recent result with date):			
Donor	Mixed	Recipient	Not performed
			Date: (mm/dd/yyyy)
State percentage: donor	%	recipient	%
Current disease status:		Date of assessment: (mm/dd/yyyy)	

TRANSPLANT RELATED COMPLICATIONS IN PATIENT:

GVHD: (Grade/organs involved and treatment received)					
Acute:	yes	no	Grade:	Resolved: yes	no
Chronic:	yes	no	Grade:	Resolved: yes	no
Serious infectious: (State type and treatment received)					
Resolved: yes no					
Organ toxicity/Other: (describe type and treatment received)					
Resolved: yes no					

CURRENT CLINICAL STATUS OF PATIENT:

Physical examination: (state significant findings)
Current medication:
Describe any intensive medical support the recipient is receiving e.g.: ventilation, dialysis etc.:

CURRENT CLINICAL STATUS OF PATIENT (LABORATORY DATA):

Blanks are considered to represent normal results			
Urea:	mg/dL	AST:	U/L
Creatinine:	mg/dL	Alcaline Phosphatase:	U/L
Bilirubin:	mg/dL	Chest X-ray:	

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CURRENT CLINICAL STATUS OF PATIENT (LABORATORY DATA):

Blanks are considered to represent normal results	
WBC:	
Neutrophils:	Blasts:
Lymphocytes:	Others:
Hemoglobin: g/dL Frequency of red blood cell transfusions:	
Date of last red cell transfusion:(mm/dd/yyyy)	
Platelet..... x 10 ⁹ /L Frequency of platelet transfusion:	
Date of last platelet transfusion:(mm/dd/yyyy)	

DETAILS ON PLANNED NEW SCT:

Planned recipient treatment (with dates):		
Is product manipulation planned?:	YES	NO
If yes, briefly describe the planned manipulation:		
Prophylaxis for GVHD:		
Is a back-up available?	YES	NO
Is there an alternative suitable unrelated donor?	YES	NO
Is there an alternative suitable unrelated cord blood unit?	YES	NO
Other comments:		

REQUIRED DOCUMENTATION TO ACCOMPANY THIS REQUEST:

Form RC308-I or Form RC308-m and/or Form RC308-p

Person Completing Form:	Signature:	Date (mm/dd/yyyy):
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