Reset

Italian Bone Marrow Donor Registry

Form RC309 (V6 1/4 ago. 2021)

WMDA Accredited

Previous transplant history and Formal request for subsequent stem cell collection

To be completed by the transplant center

TRANSPLANT CENTER:

TC IBMDR code:	Contact person:

PATIENT DATA:

Patient ID:
Date of birth:……..…….... (mm/dd/yyyy)

REQUESTED DONOR DATA:

Donor GRID:

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 desidered if 1st preference not possible

REASON FOR THE REQUEST:

If HPC request: ☐ relapse ☐ no engraftment

If lymphocyte request:

☐ Prophylaxis

☐ Pre-emptive (Please specify: ☐ Mixed chimerism ☐ Molecular relapse

☐ Haematological relapse

Other (Specify):……

Pre-transplant diagnosis :
Disease status at time of first transplant:

PREFERRED COLLECTION DATE (mm/dd/yyyy):

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

The donor clearance must be received by: …… …..... ……(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)..

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Subsequent stem cell collection request for the patient

(Patient ID)……

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-reducted Did the conditioning regimen include TBI? ☐ YES ☐ NO	
GvHD prophylaxis administered:		
Livello di matching:	☐ 6/8 ☐ 7/8 ☐ 8/8	☐ 7/10 ☐ 8/10 ☐ 9/10 ☐ 10/10

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)

PATIENT TRANSPLANT RELATED COMPLICATIONS:

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 ☐

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(Patient ID)……

PATIENT CURRENT CLINICAL STATUS:

Physical examination: (state significant findings)

Current medication:

In case of ongoing immunosuppressive therapy, please specify:

Started on: ……..(mm/dd/yyyy) Scheduled suspension date:…… (mm/dd/yyyy)

Describe any intensive medical support the recipient is receiving e.g.: ventilation, dialysis etc..:

……..

PATIENT CURRENT CLINICAL STATUS (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:	

PATIENT CURRENT CLINICAL STATUS (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)

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(Patient ID).....

DETAILS ON PLANNED NEW SCT:

Planned recipient treatment (with dates):		
Is product manipulation planned?: ☐ YES ☐ NO If yes, briefly describe the planned manipulation:		
GVHD Prophylaxis:		
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-l (Prescription for human peripheral blood lymphocyte collection) or

Form RC308-m (Prescription for human bone marrow collection) and/or

Form RC308-p (Prescription for stimulated human peripheral blood stem cell)

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