VÍDEŇSKÁ 1958 / 9
140 21 PRAHA 4 – KRČ
CZECH REPUBLIC

IKEM

INSTITUTE FOR CLINICAL AND EXPERIMENTAL MEDICINE
CZECH STEM CELLS REGISTRY

FORMAL REQUEST FOR HUMAN STEM CELL COLLECTION

(To be completed by the transplant center)

PATIENT DATA:

Patient name:		Patient ID number: (assigned by patient's registry)		
Patient registry**:**		Patient ID number: (assigned by donor's registry)		
Diagnosis:		Current disease status:		
Date of birth: (Day/Month/Year)	Gender:	Weight: kg	CMV:	Blood Group:

TRANSPLANT CENTRE:

Hospital:	Contact name:
Address:	Phone no:
	Fax no:
	Email:

DONOR DATA:

Donor ID number:		Donor's Registry:		
Age or date of birth: (Day/Month/Year)	Gender:	Weight: kg	CMV:	Blood Group:

PRODUCT REQUEST:

Product Preference: _____ **Human Bone Marrow (BM)** _____**Stimulated Human 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

Reason for product preference:

Are any other donors still under consideration for donation on behalf of this patient? ☐ Yes ☐ No
Are any other donors in the process of physical examination on behalf of this patient? ☐ Yes ☐ No
If you have answered yes to either of these questions, is this donor requested for stem cell collection on this form the preferred donor? ☐ Yes ☐ No

PROTOCOL DATA (A *brief* protocol flow chart may be enclosed):

Products that are *included* in the protocol and therefore may later be requested:
One DLI ☐ >1 DLIs ☐ (Number:____) Additional BM ☐ Additional PBSC ☐
Other ☐ (Please specify):

TRANSPLANT HISTORY

Has this patient received any previous stem cell transplants? ☐ YES ☐ NO
If YES, specify source of stem cells: ☐ Autologous ☐ Related Donor ☐ Allogeneic Donor ☐ Cord Blood

PREFERRED DATES (in order of preference):

For marrow harvest, list preferred harvest date. For PBSC collection, please list your preference for the **first** day's collection:

	Marrow Collection Date: (D/M/Y)		1st PBSC Collection Date (D/M/Y)		Corresponding Infusion Date: (D/M/Y)
1		1		1	
2		2		2	
3		3		3	

Minimum number of days prior to collection that donor clearance must be received: _____
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).

REQUIRED DOCUMENTATION TO ACCOMPANY THIS REQUEST

1. Final Compatibility Test Results form / copy of laboratory HLA typing results of patient and donor.
2. Summary of transplant protocol to be used with the most recent protocol review date.
3. Completed Marrow and/or PBSC Prescription form(s).

Person Completing Form:	Signature:	Date: (Day/Month/Year)

Address:
Institute for Clinical and Experimental Medicine
Czech Stem Cells Registry – Bldg. Z4
Vídeňská 1958/9
140 21 Prague 4, Czech Republic

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FINAL COMPATIBILITY TEST RESULTS

(To be submitted with Formal Request for Stem Cell Collection forms)

PATIENT INFORMATION

Patient name:	Patient ID number: (assigned by patient's registry)
Transplant center:	Patient ID number: (assigned by donor's registry)

Patient HLA typing results:

	A	B	C	DRB1
First antigen:				
Second antigen:				
Testing method	☐ Sero. ☐ DNA	☐ Sero. ☐ DNA	☐ Sero. ☐ DNA	☐ Sero. ☐ DNA

	DRB3/4/5	DQB1	DQA1	DPB1	DPA1
First antigen:					
Second antigen:					
Testing method	☐ Sero. ☐ DNA	☐ Sero. ☐ DNA	☐ Sero. ☐ DNA	☐ Sero. ☐ DNA	☐ Sero. ☐ DNA

DONOR INFORMATION

Donor registry:	Donor ID number:

Donor HLA typing results:

	A	B	C	DRB1
First antigen:				
Second antigen:				
Testing method	☐ Sero. ☐ DNA	☐ Sero. ☐ DNA	☐ Sero. ☐ DNA	☐ Sero. ☐ DNA

	DRB3/4/5	DQB1	DQA1	DPB1	DPA1
First antigen:					
Second antigen:					
Testing method	☐ Sero. ☐ DNA	☐ Sero. ☐ DNA	☐ Sero. ☐ DNA	☐ Sero. ☐ DNA	☐ Sero. ☐ DNA

Transplant Center representative completing form:	Signature:	Date: (Day/Month/Year)

Address:
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PRESCRIPTION FOR HUMAN BONE MARROW COLLECTION

(To be completed by the Transplant center)

Patient name:	Patient ID number: (assigned by patient's registry)
Transplant center:	Patient ID number: (assigned by donor's registry)
Donor registry:	Donor ID number:

PRE-COLLECTION PERIPHERAL BLOOD SAMPLES *(maximum 50 mls)*:

	mls EDTA		mls ACD	Other, please specify:
	mls Heparin		mls no anticoagulant	

Samples to be shipped to: Name: Address: **NOTE:** This blood will be shipped at the time of the donor physical exam unless otherwise requested.	**Invoice(s)** to be sent to: Name: Address: **NOTE:** All invoices associated with the blood sample procurement / shipment, donor work-up and stem cell collection should be sent to this address for payment **(list only the requesting hub's address).**
Phone no:	Phone no:
Fax no:	Fax no:
Email:	Email:

MARROW COLLECTION

Required Nucleated Cells/kg (uncorrected)	X 10^8/kg
x recipient weight (kg)	kg
= Total Nucleated Cells for recipient (uncorrected)	X 10^8
+ Nucleated Cells for quality assurance	X 10^8
= Total Nucleated Cells	X 10^8
IRB/Ethics Board (or equivalent) Approval	(Yes/No/Not Applicable or Date)

DISCLAIMER: The cell products collected from this donor are intended solely for the purpose of immediate therapeutic treatment for the above mentioned patient. Excess cells may be stored for future infusion for this patient. No other uses of these cells are permissible. Cells not used for the therapeutic treatment of the above mentioned patient must be disposed of properly. The donor center must be provided detailed information concerning the use and/or disposal of all portions of this cell product. By accepting these cells, the transplant physician also accepts these terms and conditions. Requests for deviations from these terms must be submitted in writing to the donor center for approval.

Required anticoagulant: Heparin _____u/mls ACD _____vol ACD/vol BM Other (please specify):
Required media for marrow transportation:
Transport Temperature: (Special packing materials such as gel packs must be provided by the transplant center unless alternative arrangements have been made with the donor or collection center)

PERIPHERAL BLOOD SAMPLES TO BE COLLECTED AT TIME OF COLLECTION *(maximum 50 mls)*

	mls EDTA		mls ACD		mls Product Sample
	mls Heparin		mls no anticoagulant	Other:	
Additional comments:					

Transplant physician:	Signature:	Date: (Day/Month/Year)

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PRESCRIPTION FOR STIMULATED HUMAN PERIPHERAL BLOOD STEM CELL COLLECTION

(To be completed by the Transplant center)

Patient name:	Patient ID number: (assigned by patient's registry)
Transplant center:	Patient ID number: (assigned by donor's registry)
Donor registry:	Donor ID number:

PRE-COLLECTION PERIPHERAL BLOOD SAMPLES *(maximum 50 mls)*:

	mls EDTA		mls ACD	Other, please specify:
	mls Heparin		mls no anticoagulant	

Samples to be shipped to: Name: Address: **NOTE:** This blood will be shipped at the time of the donor physical exam unless otherwise requested.	**Invoice(s)** to be sent to: Name: Address: **NOTE:** All invoices associated with the blood sample procurement/ shipment, donor work-up and stem cell collection should be sent to this address for payment **(list only the requesting hub's address).**
Phone no:	Phone no:
Fax no:	Fax no:
Email:	Email:

STIMULATED PBSC COLLECTION:

Required CD34 pos. cells / kg	X 10^6/kg
X recipient weight (kg)	kg
= total number of CD34 pos. cells	X 10^6
+ CD34 pos. cells for quality testing	X 10^6
= total number of CD34 pos. cells	X 10^6
IRB/Ethics Board (or equivalent) Approval	(Yes/No/Not Applicable or Date)

DISCLAIMER: The cell products collected from this donor are intended solely for the purpose of immediate therapeutic treatment for the above mentioned patient. Excess cells may be stored for future infusion for this patient. No other uses of these cells are permissible. Cells not used for the therapeutic treatment of the above mentioned patient must be disposed of properly. The donor center must be provided detailed information concerning the use and/or disposal of all portions of this cell product. By accepting these cells, the transplant physician also accepts these terms and conditions. Requests for deviations from these terms must be submitted in writing to the donor center for approval.

Preferred method of overnight storage (if needed) of apheresed product(s):	Donor Plasma Requirements: (Yes or No) If Yes, amount:
Transport Temperature: (Special packing materials such as gel packs must be provided by the transplant center unless alternative arrangements have been made with the donor or collection center)	
Additional comments:	

PERIPHERAL BLOOD SAMPLES TO BE COLLECTED AT FIRST APHERESIS *(maximum 50 mls)*

	mls EDTA		mls ACD		mls Product Sample
	mls Heparin		mls no anticoagulant	Other:	
Additional comments:					

Transplant physician:	Signature:	Date: (Day/Month/Year)

Address:
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