ศูนย์บริการโลหิตแห่งชาติ
สภากาชาดไทย

TSCDR
Thai National Stem Cell Donor Registry

Henri-Dunant Road Pathumwan Bangkok Thailand 10330
Phone: +662-263-9600 ext 1301, 1314
E-mail: tscdr.coordinators@redcross.or.th

HPC,MARROW; HPC, APHERESIS; MNC REQUEST FORM FOR TRANSPLANT CENTER

F10

PATIENT DATA				
Patient first name:			Patient last name:	
Patient registry:				
Diagnosis:			Current disease stage:	
Patient ID: (assigned by patient registry)			Patient ID: (assigned by donor registry)	
Transplant centre:				
Date of birth: (DD-MM-YYYY)	Sex:	Weight: (kg)	CMV:	Blood group/RhD:

DONOR DATA				
Donor registry:				
Donor ID:			GRID:	
Date of birth: (DD-MM-YYYY)	Sex:	Weight: (kg)	CMV:	Blood group/RhD:

Product delivery address:	**Invoice(s) to be sent to:**
Institution:	Institution:
Address:	Address:
ZIP code:	ZIP code:
City:	City:
Country:	Country:
Attention:	Attention:
Phone:	Phone:
Fax:	Fax:
E-mail:	E-mail:

PRODUCT REQUEST

- ☐ HPC, Marrow ONLY
- ☐ HPC, Apheresis ONLY
- ☐ HPC, Marrow, second option: HPC, Apheresis
- ☐ HPC, Apheresis, second option: HPC, Marrow
- ☐ MNC, ○ Apheresis ○ Whole blood ○ Buffy coat (Thai pt. only), please specify number of DLI (e.g. 1st, 2nd):

Reason for product preference:

DONOR PREFERENCE (in case of HPC, Marrow and/or HPC, Apheresis)		
Are any other donors under consideration for donation of behalf of this patient?	○ Yes	○ No
Are any other donors in process of physical examination on behalf of this patient?	○ Yes	○ No
If you have answered yes to either of these questions above, is this donor requested for stem cell collection on this form the preferred donor?	○ Yes	○ No

If no, please explain:

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PATIENT DATA	
Patient first name:	Patient last name:
Patient registry:	
Patient ID: (assigned by patient registry)	Patient ID: (assigned by donor registry)

DONOR DATA	
Donor registry:	
Donor ID:	GRID:

PROTOCOL DATA please enclose a brief protocol flow chart if applicable

Products that are included in the protocol and therefore may later be requested:

❑ Additional HPC, Marrow ❑ Additional HPC, Apheresis ❑ MNC, Apheresis, please specify number of DLI:

❑ Other, please specify:

Total days of conditioning regimen the patient will receive prior to infusion:

This includes chemotherapy for days, and radiation for days

TRANSPLANT HISTORY

Has this patient received any previous stem cell transplants? ○ Yes ○ No

If yes, please include TSCDR Form F20 and answer following transplant history questions.

List types and dates of previous (allogenic) transplants:

Specify source of stem cells:

Reason for subsequent transplant:

These questions are only to be answered in case of DLI:

Did the donor being requested above previously donate stem cells on behalf of this patient?	○ Yes	○ No
Was any of the original stem cell product cryopreserved for later infusion?	○ Yes	○ No
If yes, was that product infused?	○ Yes	○ No

PREFERRED DATES (in order of preference)	
(First) collection date: (DD-MM-YYYY)	Corresponding infusion date: (DD-MM-YYYY)
1	1
2	2
3	3
Minimum number of days prior to collection that donor clearance must be received:	

CRYOPRESERVATION

Cryopreservation planned: ○ No ○ Yes (If yes, select location): ○ TC ○ TSCDR ○ Other:

If yes, please specify reason for cryopreservation:

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Patient registry:	
Patient ID: (assigned by patient registry)	Patient ID: (assigned by donor registry)

DONOR DATA	
Donor registry:	
Donor ID:	GRID:

PRE-COLLECTION SAMPLES *(Note: Blood draw at WU date, 30 ml is the maximum volume that can be requested)*	
Are pre-collection samples required? ○ Yes ○ No	
EDTA _____ mL	Clotted blood _____ mL

PRE-COLLECTION SAMPLES TO BE SHIPPED TO:	
Pre-collection shipping address is the same as product delivery address? ○ Yes ○ No If no, please specify:	
Institution:	
Address:	
City:	ZIP code:
Country:	
Contact person:	
Phone:	Fax:
E-mail:	

STEM CELL AND / OR LYMPHOCYTE COLLECTION	
Requested uncorrected nucleated cells per kg (BM request only):	$x10^8$ / Kg.
Requested CD34+ cell per kg:	$x10^6$ / Kg.
Requested CD3+ count per kg (DLI request only):	$x10^8$ / Kg.
Please provide explanation for high number of cells (CD34+ > 6 $x10^6$ cells/kg patient body weight):	

In case of HPC Apheresis requested, answer the following question:
TSCDR recommends a nucleated cell concentration of less than 300 $x10^9$/L for transport oversea or overnight product
Reduce WBC concentration to < 300$x10^9$/L by the addition of donor plasma or another additive? ○ Yes ○ No
If no, please indicate the desired final concentration:
Which additive would TC prefer to use for diluting WBC? ○ Donor plasma ○ 5% human serum albumin
Noted: The TSCDR's laboratory may use donor plasma along with 5% human serum albumin in case of the donor plasma is not enough for diluting.

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PATIENT DATA	
Patient first name:	Patient last name:
Patient registry:	
Patient ID: (assigned by patient registry)	Patient ID: (assigned by donor registry)

DONOR DATA	
Donor registry:	
Donor ID:	GRID:

ADDITIONAL SAMPLES TO ACCOMPANY STEM CELL OR LYMPHOCYTE PRODUCT

Donor plasma in a separate bag required? ○ Yes ○ No If yes, please indicate volume of plasma:

Additional samples required? ○ Yes ○ No

Indicate the amount and type of tube required (Note: 30 ml of PB is the maximum volume that can be requested)

Tube	Peripheral blood samples		Product samples	
	Day 1	Day 2	Day 1	Day 2
EDTA (mL)				
Clotted blood (mL)				
Microtube (mL)				

Additional comments:

REQUIRED DOCUMENTATION TO ACCOMPANY THIS REQUEST

In case of HPC, Marrow and/or HPC, Apheresis:

- Completed donor and patient HLA typing report

In case of MNC, Apheresis:

- TSCDR Form F20 Transplant History, or equivalent

DISCLAIMER:

- The cell products collected from this donor are intended solely for the purpose of immediate therapeutic treatment for the above mentioned patient. Any planned cryopreservation of the cell products prior to initial infusion to the patient may only occur with the advance written approval from the donor centre.
- Excess cells may be stored for future therapeutic treatment 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 and details must be provided to the donor centre.
- The donor centre 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. Deviations from these terms are not permitted without prior written approval from the donor centre.
- Any serious product events and/or adverse reactions must be reported both to the donor's registry and transplant center. Corresponding S(P)EAR reports must be completed by the registry providing the product, submitted to the WMDA office and details must provided to the donor centre.

Review by physician
Transplant physician name:

Person completing form:	Date: (DD-MM-YYYY)	Signature: