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| **RECIPIENT IDENTIFICATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| First name | |  | | | | | | | | | | | | Middle name | | | | | | | |  | | | | | | | | | | | | Surname | | | |  | |
|  |  | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | |  | | |  | |
| DOB day/month/year |  | | | | | | | | | | | | Sex at Birth | | | | | | | | Male  Female | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | |  | | |  | |
| ID assigned by Anthony Nolan |  | | | | | | | | | | | | ID assigned by recipient’s TC | | | | | | | |  | | | | | | | | | | | | | | ID assigned by recipient’s Int registry | | |  | |
|  |  | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | |  | | |  | |
| Diagnosis |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date of diagnosis | | |  | |
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| Has the patient previously received a stem cell transplant from an alternative donor or any other allogeneic cellular therapy (related or unrelated)? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | |
|  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| If yes, provide details | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Are any other donors in work up for this recipient? | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| If **yes**, is this donor the primary donor or the back up donor? | | | | | | | | | | | | | | | | | | | | | Primary  Back up | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| Have any unrelated donors or cord blood units been identified? | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| If yes, provide details | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | |  | | |  | |
| Reason for asking Anthony Nolan to facilitate request: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **RELATED DONOR IDENTIFICATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| First name |  | | | | | | | | | | | Middle name | | | | | | | | | | | |  | | | | | | | | | Surname | | | | |  | |
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| GRID if known |  | |  |  |  | | |  |  |  |  | | | |  |  |  |  |  |  | | |  |  |  | |  |  |  |  |  |  | | | Donor ID if known | | |  | |
|  |  | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | |  | | |  | |
| DOB\*\* day/month/year |  | | | | | | | | | | | | Sex at Birth | | | | | | | | Male  Female | | | | | | | | | | | | | | Relationship to patient | | |  | |
| \*\* the donor must be a minimum age of 16 years old | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Mobile no incl. country code, if applicable |  | | | | | | | | | | | | | | | | | | | | Alternative contact no | | | | | | | | | | | | | |  | | | | |
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| Has the donor been informed that this request has been made? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | |
|  |  | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | |  | | |  | |
| Has the donor been educated on potentially becoming a stem cell donor? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | |
|  |  | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | |  | | |  | |
| Is the donor able to understand spoken and written English? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | |
|  |  | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | |  | | |  | |
| If no, please advise us of the donor’s first/preferred language? | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | |
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| **CONCURRENT VT / WUs** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you require donor VT blood samples to be drawn at medical for a **concurrent VT / WU**? \*\* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | |  | |
| \*\* If you have already requested VT samples via Anthony Nolan do not complete anything below.   * **For GIAS Transplant Centres: If yes, please leave the sample requirements/shipment details below blank and tick here**   **For International Registries: If the TC has ticked above to advise they are a GIAS Transplant Centre please send:**   * **2 x 4ml EDTA** * **1 x 4ml no anticoagulant**   **to the following address: Anthony Nolan Histocompatibility Laboratories, 77B Fleet Road, London NW3 2QU, UK**     * **For non-GIAS TCs: If yes, please provide sample requirements and shipment details below** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
|  | ml EDTA | | | | | | | | | | | |  | | | | | | | | ml ACD | | | | | | | | | | | | | |  | | |  | |
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|  | ml Heparin | | | | | | | | | | | |  | | | | | | | | ml no anticoagulant | | | | | | | | | | | | | |  | | |  | |
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| **Samples to be delivered to:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Centre name |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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**REQUIRED DOCUMENTATION:**

please include copies of recipient and donor high-resolution tissue typing reports (unless this is a concurrent VT / WU and high-resolution typing reports are not yet available)

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| Name of individual completing form |  | Signature |  | Date day/month/year |  |

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| **RECIPIENT IDENTIFICATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First name | |  | | | | | | | | | | Middle name | | | | | | | | | | |  | | | | | | | | Surname | |  |
|  | |  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | |  |
| ID assigned by Anthony Nolan | |  | | | | | | | | | | ID assigned by recipient’s TC | | | | | | | | | | |  | | | | | | | | ID assigned by recipient’s Int registry | |  |
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| Weight kg | |  | | | | | | | | | | ABO rh | | | | | | | | | | |  | | | | | | | | CMV status | |  |
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| **TRANSPLANT CENTRE** | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Centre name | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Phone number | |  | | | | | | | | | | | | | | | | | | | | | Out of hours number | | | | | | | |  | | |
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| Email | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DONOR IDENTIFICATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| First name | |  | | | | | | | | | | Middle name | | | | | | | | | | |  | | | | | | | | Surname | |  |
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| GRID if known | |  |  | |  | |  |  |  |  |  | |  | |  |  |  |  |  |  |  | | |  |  |  |  |  |  |  | Donor ID if known | |  |
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| **PRODUCT TYPE** |
|
| \* Please fill in a numerical value next to both products to indicate preference: 1 – 1st preference 2 – 2nd preference 0 – not wanted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Bone marrow (BM)** | |  | | | | | | | | | | | | | | | | | | | | | **PBSC** | | | | | | | |  | | |
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| Is this donor requested to consent to participate in an AN-approved clinical trial? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | No |
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| If yes, what is the name of the trial? | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
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| **PREFERRED DATES (in order of preference)** | | | | | | | | | | | | | |
|
| For BM list preferred date of collection, for PBSC list preferred first date of collection | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Collection date: (day/month/year)** | | | | | | | | | | | | | | | | | | | | | | | **Corresponding infusion date: (day/month/year)** | | | | | | | | | | |
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| Minimum number of days clearance received prior to collection | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
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| Number of days recipient conditioning required prior to transplant | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
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| Date donor clearance is required by for first choice dates | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
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| Do you plan to cryopreserve all the cells? | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | |
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| If yes, please tick reason one option only | | | | | | | | | | | | | | | | | | | | | | | Covid-19  Patient reasons  Donor reasons | | | | | | | | | Logistical reasons  Other | |
|  | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| Please provide a short explanation for selecting the above reason | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
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| **REQUIRED DOCUMENTATION: please include copies of recipient and donor high resolution tissue typing reports, and HLA typing form** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of individual completing form | |  | | | | | | | | | | Signature | | | | | | | | | | |  | | | | | | | | Date day/month/year | |  |

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| **RECIPIENT IDENTIFICATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| First name | |  | | | | | | | | | Middle name | | | | | | | | | |  | | | | | | | | Surname |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ID assigned by Anthony Nolan | |  | | | | | | | | | ID assigned by recipient’s TC | | | | | | | | | |  | | | | | | | | ID assigned by recipient’s Int registry |  |
| **DONOR IDENTIFICATION** | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | |  |  |
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| GRID if known | |  |  |  |  | |  |  |  |  | |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | Donor ID if known |  |
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| **PRE-COLLECTION PERIPHERAL BLOOD SAMPLES** maximum 100 ml **Note**: This blood will be drawn at the donor’s medical unless otherwise requested | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | ml EDTA | | | | |  | | | | | | | ml ACD | | | | | | | | Other samples  Please specify type/amount | | | | | | | |  | |
|  |  | | | | |  | | | | | | |  | | | | | | | |  | | | | | | | |  | |
|  | ml Heparin | | | | |  | | | | | | | ml no anticoagulant | | | | | | | |  | | | | | | | |  | |
| **Samples** to be delivered to | | | | | | | | | | | | | | | | | | | | | **Product** to be delivered to | | | | | | | | | |
| Centre name | |  | | | | | | | | | | | | | | | | | | | Centre name | | | | | | | |  | |
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| STIMULATED PBSC COLLECTION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| CD34+ cells per kg requested | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | x 10 ^6/kg | |
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| x recipient weight (kg) | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | kg | |
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| = total number of CD34+ cells | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | x 10 ^6 | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |  | |
| + CD34+ cells for quality testing | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | x 10 ^6 | |
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| = total number of CD34+ cells for recipient | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | x 10 ^6 | |
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| **Note i: If autologous plasma is not available for dilution HAS will be used;** | | | | | | | | | | | | | | | | | | | | | **Note ii: Product will be transported cooled with ice packs** | | | | | | | | | |
| For Anthony Nolan donors we aim for a CD34+ cell count of **4 x 10^6/kg**. A brief explanation is required if a count of **6 or higher** is requested: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **CELL DILUTION         Cells must be diluted with plasma to a final TNC concentration of <200 x 10^6/ml** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| |  |  | | --- | --- | | **Comments:** | 1. **Aim for a haemocrit level of less than 4%** 2. **Leave a 10-20cm bleed line on each bag for sterile clamping & docking** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Any additional comments:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **PERIPHERAL BLOOD SAMPLES TO BE COLLECTED AT FIRST APHERESIS** maximum 100 ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | ml EDTA | | | | |  | | | | | | | ml ACD | | | | | | | | Other samples  Specify type/amount | | | | | | | |  | |
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|  | ml Heparin | | | | |  | | | | | | | ml no anticoagulant | | | | | | | | Additional plasma Specify amount in ml | | | | | | | |  | |
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| Clinical prescriber completing form | |  | | | | | | | | | Signature | | | | | | | | | |  | | | | | | | | Date day/month/year |  |
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| **RECIPIENT IDENTIFICATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First name | |  | | | | | | | | | Middle name | | | | | | | | | |  | | | | | | | | | Surname |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ID assigned by Anthony Nolan | |  | | | | | | | | | ID assigned by recipient’s TC | | | | | | | | | | |  | | | | | | | | ID assigned by recipient’s Int registry |  |
| **DONOR IDENTIFICATION** | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | |  |  |
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| First name | |  | | | | | | | | | Middle name | | | | | | | | | |  | | | | | | | | | Surname |  |
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| **PRE-COLLECTION PERIPHERAL BLOOD SAMPLES** maximum 100 ml **Note**: This blood will be drawn at the donor’s medical unless otherwise requested | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | ml EDTA | | | | |  | | | | | | | ml ACD | | | | | | | | | Other samples  Specify type/amount | | | | | | | |  | |
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|  | ml Heparin | | | | |  | | | | | | | ml no anticoagulant | | | | | | | | | | | | | | | | |  | |
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| **Samples** to be delivered to | | | | | | | | | | | | | | | | | | | | | | **Product** to be delivered to | | | | | | | | | |
| Centre name | |  | | | | | | | | | | | | | | | | | | | | Centre name | | | | | | | |  | |
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| Contact name | |  | | | | | | | | | | | | | | | | | | | | Contact name | | | | | | | |  | |
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| BONE MARROW COLLECTION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nucleated cells per kg requested | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | x 10 ^8/kg | |
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| x recipient weight kg | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | kg | |
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| + nucleated cells for quality testing | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | x 10 ^8 | |
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| = total number of nucleated cells for recipient | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | x 10 ^8 | |
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| Anticoagulant | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
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| Transport temperature | | | | | | | | | | | Cooled with ice packs | | | | | | | | | | | | | | | | | | | Room Temperature | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Additional comments | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
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| **PERIPHERAL BLOOD SAMPLES TO BE COLLECTED AT TIME OF COLLECTION** maximum 100 ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | ml EDTA | | | | |  | | | | | | | ml ACD | | | | | | | | | Other samples  Specify type/amount | | | | | | | |  | |
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|  | ml Heparin | | | | |  | | | | | | | ml no anticoagulant | | | | | | | | | | | | | | | | |  | |
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| Clinical prescriber completing form | |  | | | | | | | | | Signature | | | | | | | | | |  | | | | | | | | | Date day/month/year |  |