|  |
| --- |
| **RECIPIENT IDENTIFICATION**  |
|  |
| 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 |   |
|  |  |  |  |
| 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 |   |
|  |  |
| 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: |   |
|  |  |  |  |  |  |
| **RELATED DONOR IDENTIFICATION** |
|  |
| First name |       | Middle name |       | Surname |       |
|  |  |
| 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 |   |
|  |  |
|  |   |
|  |  |  |  |  |  |
| Mobile no incl. country code, if applicable |   | Alternative contact no  |   |
|  |  |  |  |  |  |
| Email |   |
|  |  |  |  |  |  |
| 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? |  |   |
|  |  |  |
|  |  |  |
|  |  |  |  |
| **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 |  |  |
|  |  |  |  |  |  |
|   | ml Heparin |   | ml no anticoagulant |  |  |
|  |  |  |  |  |  |
| **Samples to be delivered to:**  |
|  |
| Centre name |   |
|  |  |  |  |  |  |
| Address |   |
|  |  |  |  |  |  |
|  |   |
|  |  |
| Contact name |   |
|  |  |  |  |  |  |
| Phone number |   |
|  |  |
| Out of hours number |   |
|  |  |  |  |  |  |
| Email |   |
|  |  |
|  |  |  |  |  |  |

**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)

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

|  |
| --- |
| **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 |   |
|  |  |  |  |  |  |
| Weight kg |   | ABO rh |   | CMV status |   |
|  |
| **TRANSPLANT CENTRE**  |  |
| Centre name |   |
|  |  |
| Address |   |
|  |  |
|  |   |
|  |  |  |  |
| Contact name |   |
|  |  |  |  |
| Phone number |   | Out of hours number |   |
|  |  |  |  |
| Email |   |
| **DONOR IDENTIFICATION** |
|  |  |
| First name |   | Middle name |   | Surname |   |
|  |  |  |  |  |
| GRID if known |   |   |   |   |  |   |   |   |   |  |   |   |   |   |  |   |   |   |   |  |   |   |   | Donor ID if known |   |
|  |  |  |  |  |
| Weight kg |   | ABO rh |   | CMV status |   |
|  |  |  |  |  |  |
| **PRODUCT TYPE** |
|
| \* Please fill in a numerical value next to both products to indicate preference: 1 – 1st preference 2 – 2nd preference 0 – not wanted |
|  |
| **Bone marrow (BM)**  |   | **PBSC** |   |
|  |  |  |  |
| Is this donor requested to consent to participate in an AN-approved clinical trial?  | [ ]  Yes  | [ ]  No |
|  |  |
| If yes, what is the name of the trial?  |   |
|  |  |
| **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)** |
|  |  |
|  |   |  |   |
|  |  |  |  |
|  |   |  |   |
|  |  |  |  |
|  |   |  |   |
|  |  |  |  |
| Minimum number of days clearance received prior to collection  |   |
|  |  |
| Number of days recipient conditioning required prior to transplant  |   |
|  |  |
| Date donor clearance is required by for first choice dates |   |
|  |  |
| Do you plan to cryopreserve all the cells? | [ ]  Yes [ ]  No |
|  |  |
| 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 |   |
|  |  |
| **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 |   |

|  |
| --- |
| **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** |  |  |  |  |
|  |  |  |  |  |  |
| First name |   | Middle name |   | Surname |   |
|  |  |  |  |  |  |
| GRID if known |   |   |   |   |  |   |   |   |   |  |   |   |   |   |  |   |   |   |   |  |   |   |   | Donor ID if known |   |
|  |  |  |  |  |  |
| **PRE-COLLECTION PERIPHERAL BLOOD SAMPLES** maximum 100 ml **Note**: This blood will be drawn at the donor’s medical unless otherwise requested |
|  |
|   | ml EDTA |   | ml ACD | Other samplesPlease specify type/amount |   |
|  |  |  |  |  |  |
|   | ml Heparin |   | ml no anticoagulant |  |  |
| **Samples** to be delivered to | **Product** to be delivered to |
| Centre name |   | Centre name |   |
|  |  |  |  |
| Address |   | Address |   |
|  |  |  |  |
|  |   |  |   |
|  |  |  |  |
| Contact name |   | Contact name |   |
|  |  |  |  |
| Phone number |   | Phone number |   |
|  |  |  |  |
| Out of hours number |   | Out of hours number |   |
|  |  |  |  |
| Email |   | Email |   |
|  |  |  |  |
| STIMULATED PBSC COLLECTION |
|  |
| CD34+ cells per kg requested |   | x 10 ^6/kg |
|  |  |  |
| x recipient weight (kg) |   | kg |
|  |  |  |
| = total number of CD34+ cells |   | x 10 ^6 |
|  |  |  |
| + CD34+ cells for quality testing  |   | x 10 ^6 |
|  |  |  |
| = total number of CD34+ cells for recipient |   | x 10 ^6 |
|  |  |  |
| **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: |
|  |
|   |
| **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**
 |

 |
|  |
| **Any additional comments:**   |
|  |
| **PERIPHERAL BLOOD SAMPLES TO BE COLLECTED AT FIRST APHERESIS** maximum 100 ml |
|  |
|   | ml EDTA |   | ml ACD | Other samplesSpecify type/amount |   |
|  |  |  |  |  |  |
|   | ml Heparin |   | ml no anticoagulant | Additional plasma Specify amount in ml |   |
|  |  |  |  |  |  |
|  |
| Clinical prescriber completing form |   | Signature  |  | Date day/month/year |  |
|  |  |  |  |  |  |

|  |
| --- |
| **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** |  |  |  |  |
|  |  |  |  |  |  |
| First name |   | Middle name |   | Surname |   |
|  |  |  |  |  |  |
| GRID |   |   |   |   |  |   |   |   |   |  |   |   |   |   |  |   |   |   |   |  |   |   |   | Donor ID |   |
|  |  |  |  |  |  |
| **PRE-COLLECTION PERIPHERAL BLOOD SAMPLES** maximum 100 ml **Note**: This blood will be drawn at the donor’s medical unless otherwise requested |
|  |
|   | ml EDTA |   | ml ACD | Other samplesSpecify type/amount |   |
|  |  |  |  |  |  |
|   | ml Heparin |   | ml no anticoagulant |  |
|  |  |
| **Samples** to be delivered to | **Product** to be delivered to |
| Centre name |   | Centre name |   |
|  |  |  |  |
| Address |   | Address |   |
|  |  |  |  |
|  |   |  |   |
|  |  |  |  |
| Contact name |   | Contact name |   |
|  |  |  |  |
| Phone number |   | Phone number |   |
|  |  |  |  |
| Out of hours number |   | Out of hours number |   |
|  |  |  |  |
| Email |   | Email |   |
|  |  |  |  |
|  |
| BONE MARROW COLLECTION |
| Nucleated cells per kg requested |   | x 10 ^8/kg |
|  |  |  |
| x recipient weight kg |   | kg |
|  |  |  |
| = total number of nucleated cells |   | x 10 ^8 |
|  |  |  |
| + nucleated cells for quality testing  |   | x 10 ^8 |
|  |  |  |
| = total number of nucleated cells for recipient |   | x 10 ^8 |
|  |  |  |
| Anticoagulant  |   |
|  |  |
| Transport temperature | [ ]  Cooled with ice packs | [ ]  Room Temperature |
|  |  |
| Additional comments |   |
|  |
| **PERIPHERAL BLOOD SAMPLES TO BE COLLECTED AT TIME OF COLLECTION** maximum 100 ml |
|  |
|   | ml EDTA |   | ml ACD | Other samplesSpecify type/amount |   |
|  |  |  |  |  |  |
|   | ml Heparin |   | ml no anticoagulant |  |
|  |  |  |  |  |  |
|  |
| Clinical prescriber completing form |   | Signature  |  | Date day/month/year |  |