Ministry of Health
National Registry of Hematopoietic Stem Cells Voluntary Donors

CB30

CORD BLOOD UNIT SHIPMENT REQUEST

PATIENT DATA			
Patient first name:		Patient last name:	
Patient registry:			
Transplant centre:			
Patient ID: (assigned by patient registry)		Patient ID: (assigned by donor registry)	
Date of Birth: (YYYY-MM-DD)	Gender:	Weight: (kg)	Blood group/Rh(D):
Diagnosis:		Estimated transplant date: (YYYY-MM-DD)	

PATIENT HLA					
Locus:	A	B	C	DRB1	DQB1
First antigen:					
Second antigen:					
◯Initial typing ◯Verification typing			Typing date: (YYYY-MM-DD)		
Cord Blood Unit ID:					

ADDITIONAL PRE-RELEASE CHECKS

The transplant center requests the following tests to be done on CBU at time of release and/or additional information:

Please test the following on post-cryopreservation attached segment of CBU at time of release:

- ☐ Viability test
- ☐ Colony testing (e.g. CFU-GM)
- ☐ CD34 pos test
- ☐ HLA verification test
- ☐ Additional IDM tests, please specify:
- ☐ Blood or other sample shipment, please specify:
- ☐ Maternal health questionnaire or summary statement
- ☐ Other tests:

PROPOSED TIME FRAME FOR CORD BLOOD UNIT SHIPMENT

Preferred date: (YYYY-MM-DD)	Preferred delivery time: (HH:MM + local time zone)
Start of conditioning: (YYYY-MM-DD)	Conditioning regimen: ◯Myeloablative ◯Non-myeloablative

Transplant type:

- ◯ Single cord
- ◯ Double cord
- ◯ Multiple cord
- ◯ Single cord in combination with haplo-donor
- ◯ Ex-vivo expansion transplant
- ◯ Other, please specify:

Transplant date: (YYYY-MM-DD)

Comments:

Transport to be organised by: Dry shipper to be provided by:	Preferred courier:

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

Cord blood unit to be shipped to:	**Invoice(s) to be sent to:**
Institution:	Institution:
Address:	Address:
ZIP:	ZIP:
City:	City:
Country:	Country:
Attention:	Attention:
Phone:	Phone:
Fax:	Fax:
E-mail:	E-mail:

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