DF1 DONOR ASSESSMENT POST STEM CELL DONATION

To be completed by the donor centre by phone or by the donor the following donation.

DONOR DATA	
Donor first name:	Donor last name:
Donor ID:	
GRID:	

DONATION DATA			
Hospital/Apheresis centre:		City:	
Physician name:		Date(s) of stem cell collection: (YYYY-MM-DD)	
Type of donation:	◯ Bone marrow ◯ PBSC		
	◯ 1st donation ◯ 2nd donation		

DONOR EXPERIENCE

How do you feel physically? ◯ better than usual ◯ normal ◯ worse than usual ◯ much worse than usual

How do you feel emotionally? ◯ better than usual ◯ normal ◯ worse than usual ◯ much worse than usual

After donation did you experience any of the following?

☐ tiredness	☐ insomnia	☐ fever	☐ sore throat
☐ headache	☐ vertigo	☐ bone pain	☐ pain at the site of donation
☐ night sweats	☐ stiffness	☐ nausea/vomiting	
☐ rashes	☐ loss of appetite		

Other, please specify:

Do you feel you were correctly informed and obtained a clear idea about the stem cell donation you have recently done? ◯ Yes ◯ No

Please specify:

AT THE HOSPITAL/APHERESIS CENTRE

Do you feel that the staff adequately supported you through the donation? ◯ Yes ◯ No

Please specify:

Do you feel you were well cared for by the hospital staff? ◯ Yes ◯ No

Please specify:

If no, please indicate how the staff could have provided greater assistance:

Did you encounter any particular problem related to your donation? ◯ Yes ◯ No

Please specify:

Is there anything that could have been done to make the donation a better experience for you? Or do you have any suggestions as how we can improve the care of future donors?

Before donation:

After donation:

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

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