F80

NOTIFICATION OF DONOR CLEARANCE

◯HPC, Marrow	◯HPC, Apheresis	◯MNC, Apheresis

If final clearance for donation is NOT granted, please complete form C30 instead.

SECTION A: TO BE COMPLETED BY THE APHERESIS/COLLECTION CENTRE

PATIENT DATA	
Patient first name:	Patient last name:
Patient registry:	
Date of birth: (YYYY-MM-DD)	
Patient ID: (assigned by patient registry)	Patient ID: (assigned by donor registry)

DONOR DATA				
Donor registry:			ION:	
Donor ID:				
GRID:				
Date of birth: (YYYY-MM-DD)	Gender:	Weight:(kg)	CMV:	Blood group/RhD
Transfusions:	The total number of transfused units:		Year of last transfusion (YYYY)	
Pregnacies:	Number(s):			
Red cell Irregular Antibodies:		Type of Irr. ABs:		

COLLECTION SCHEDULE INFORMATION	
Donor informed consent signed on: (YYYY-MM-DD)	Donor clearance to be confirmed on: (YYYY-MM-DD)
First date of donor G-CSF injections: (YYYY-MM-DD)	Confirmed first collection date: (YYYY-MM-DD)

TEST DATA (1/2)				
Donor Infectious Disease Test Results	Positive	Negative	Not tested	Date of blood collection: (YYYY-MM-DD)
Hepatitis B Virus (HBV)				
HBsAg (surface antigen screening test)	◯	◯	◯	
Anti-HBc (antibody screening test)	◯	◯	◯	
Anti-HBs (antibody screening test)	◯	◯	◯	
HBV-NAT (Nucleic Acid Amplification Technique)	◯	◯	◯	
Hepatitis C Virus (HCV)				
Anti-HCV (antibody screening test)	◯	◯	◯	
HCV-NAT (Nucleic Acid Amplification Technique)	◯	◯	◯	
Human T-Lymphotropic Viruses (HTLV)				
Anti-HTLV I / II (antibody screening test)	◯	◯	◯	

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NOTIFICATION OF DONOR CLEARANCE

◯HPC, Marrow ◯HPC, Apheresis ◯MNC, Apheresis

PATIENT DATA	
Patient first name:	Patient last name:
Patient registry:	
Date of birth: (YYYY-MM-DD)	
Patient ID: (assigned by patient registry)	Patient ID: (assigned by donor registry)

DONOR DATA						
Donor registry:				ION:		
Donor ID:						
GRID:						

TEST DATA (2/2)					
Donor Infectious Disease Test Results		Positive	Negative	Not tested	Date of blood collection: (YYYY-MM-DD)
Human Immunodeficiency Virus (HIV)					
HIV-1 p24 (antigen screening test)		◯	◯	◯	
HIV-NAT (Nucleic Acid Amplification Technique)		◯	◯	◯	
Anti-HIV 1/2 (antibody screening test)		◯	◯	◯	
Syphilis					
STS (serologic test)		◯	◯	◯	
Cytomegalovirus (CMV)					
CMV antibodies	IgG	◯	◯	◯	
	IgM	◯	◯	◯	
	total	◯	◯	◯	
CMV-PCR (Polymerase Chain Reaction)		◯	◯	◯	
Epstein Barr Virus (EBV)					
EBV antibodies	IgG	◯	◯	◯	
	IgM	◯	◯	◯	
	total	◯	◯	◯	
EBV-PCR		◯	◯	◯	
Other					
WNV-NAT (West Nile Virus)		◯	◯	◯	
Toxoplasmosis antibodies	IgG	◯	◯	◯	
	IgM	◯	◯	◯	
	total	◯	◯	◯	
		Normal	Elevated	Not tested	
ALT (Alanine Aminotransferase)		◯	◯	◯	
Verification test(s) if performed:					
Other tests (please specify):					

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PATIENT DATA	
Patient first name:	Patient last name:
Patient registry:	
Date of birth: (YYYY-MM-DD)	
Patient ID: (assigned by patient registry)	Patient ID: (assigned by donor registry)

DONOR DATA						
Donor registry:	ION:					
Donor ID:						
GRID:						

DONOR CLEARANCE INFORMATION

Based on the results of the donor history, examination and tests by the donor physician concludes that the donor is a fit candidate for donation.

Please note the following:

◯There is no additional donor information that requires consent from the transplant centre.

◯There is additional donor information that requires consent from the transplant centre before final clearance. Please find the information below:

Name of collection/apheresis centre:		
Donor/collection centre representative:	Date: (YYYY-MM-DD)	Donor/collection centre signature:
Reviewer checking this form:	Date: (YYYY-MM-DD)	Reviewer signature:

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PATIENT DATA	
Patient first name:	Patient last name:
Patient registry:	
Date of birth: (YYYY-MM-DD)	
Patient ID: (assigned by patient registry)	Patient ID: (assigned by donor registry)

DONOR DATA						
Donor registry:	ION:					
Donor ID:						
GRID:						

SECTION B: TO BE COMPLETED BY THE TRANSPLANT CENTER

TRANSPLANT CENTRE ACCEPTANCE OF DONOR FINAL CLEARANCE

Transplant centre conclusion about the above provided donor clearance information

I have received and reviewed the pre-collection physical examination test results of this donor, and the additional donor information (if applicable):

- ◯ I accept this donor for stem cell donation, and agree to final donor clearance. I don't require further testing or information at this time. Patient consent for transplantation has been verified.
- ◯ I need additional information or testing. *Please provide comments below in 'Comments' field.*
- ◯ I don't accept this donor for stem cell donation.

First day of patient conditioning regimen: (YYYY-MM-DD)
First collection date: (YYYY-MM-DD)
Date of transplant: (YYYY-MM-DD)

Comments:

Transplant centre contact person(s):

Telephone number:

24-hour telephone number:

Transplant centre representative:	Date: (YYYY-MM-DD)	Transplant centre signature:

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