TÜRKİYE KÖK HÜCRE KOORDİNASYON MERKEZİ
TURKISH STEM CELL COORDINATION CENTER

NOTIFICATION OF DONOR CLEARANCE

Document Number	: **TRKK F 80**	Revision No	:	Page: **1 of 3**
Effective Date	: **15.11.2018**	Date Revised	:	

☐ **HPC, Marrow** ☐ **HPC, Apheresis** ☐ **MNC, Apheresis**

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

PATIENT DATA

Patiant name:	**Date of birth: (DD-MM-YYYY)**
Patient ID:(assigned by TRKK)	**Patient ID: (assigned by patient registry)**
Transplant center:	

DONOR DATA

Donor registry:
TR TRKK TURKISH STEM CELL COORDINATION CENTER

Donor ID:		**Date of birth: (DD-MM-YYYY)**	
Blood group/RhD: **O Rh (-)NEGATIVE**		**Gender:** **FEMALE**	**Weight:(kg)**
Transfusions: **YES**	**Number/year:**	**Pregnancies:** **YES**	**Number:**

COLLECTION DATE INFORMATION (DD.MM.YYYY)

Donor informed consent signed on:	**Donor clearance confirmed on:**
First date of donor G-CSF injections:	**Confirmed first collection date:**

TEST DATA

Donor Infectious Disease Test Results	Positive	Negative	Not tested	Date of blood collection: (YYYY-MM-DD)
Hepatit B Virus (HBV)				
HBsAg(surface antigen screening test)	☐	☐	☐	
Anti HBs	☐	☐	☐	
Anti HBc IgG(antibody screening test)	☐	☐	☐	
HBV DNA	☐	☐	☐	
Hepatit C Virus (HCV)				
Anti HCV(antibody screening test)	☐	☐	☐	
HCV RNA	☐	☐	☐	
Human Immunodeflclency Virus (HIV)				
Anti HIV 1/2	☐	☐	☐	
HIV RNA	☐	☐	☐	
Syphilis				
TPHA	☐	☐	☐	
Human T-Lymphotropic Viruses (HTLV)				
Anti-HTLV 1/2 (screening test)	☐	☐	☐	

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PATIENT/DONOR DATA

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Patient ID:(assigned by TRKK)	**Patient ID: (assigned by patient registry)**

Donor registry:

TR TRKK TURKISH STEM CELL COORDINATION CENTER

Donor ID:	**Date of birth: (DD-MM-YYYY)**

TEST DATA

Donor Infectious Disease Test Results		**Positive**	**Negative**	**Not tested**	**Date of blood collection: (YYYY-MM-DD)**
Other					
CMV (Cytomegalovirus) antibodies	IgG	☐	☐	☐	
	IgM	☐	☐	☐	
	total	☐	☐	☐	
EBV (Epstein Bar Virus) antibodies	IgG	☐	☐	☐	
	IgM	☐	☐	☐	
Toxoplasmosis antibodies	IgG	☐	☐	☐	
	IgM	☐	☐	☐	
	total	☐	☐	☐	
Beta HCG		☐	☐	☐	
WNV-NAT (West Nile Virus)		☐	☐	☐	
Hemoglobin Electrophoresis (if necessary)					

Verification test(s), if performed:

Other(s), plase specify:

ADDITIONAL DONOR INFORMATION

Comments/attachments:

☐ Additional documennts attached

Based on the results of the donor history, examination and test the donor has

☐ no medical problems which would make her/him unsuitable for the donation

☐ medical problems which would make her/him unsuitable for the donation

The donor is in good health and a fit candidate for ☐ Bone Marrow ☐ PBSC ☐ MNC

Name of apheresis/ collection center:

Responsible physician (prinded name):	Date (DD.MM.YYYY):	Signature:
Reviewer checking this form (prinded name):	Date (DD.MM.YYYY):	Signature:

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PATIENT/DONOR DATA

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Patient ID:(assigned by TRKK)	**Patient ID: (assigned by patient registry)**
Donor registry: **TR TRKK TURKISH STEM CELL COORDINATION CENTER**	
Donor ID:	**Date of birth: (DD-MM-YYYY)**

SECTION B: TO BE COMPLETED BY THE TRANSPLANT CENTER

TRANSPLANT CENTER ACCEPTANCE OF DONOR FINAL CLEARENCE

I have received and rewiewed the pre-collection physical examination test results and/ or summaries from the lead collection physician for this donor.

I find that this volunteer stem cell donor is an acceptable donor for stem cell collection.

☐ Patient consent for the transplantation has been verified.

First date of patient conditioning regimen (DD-MM-YYYY)_____

Scheduled transplantation date (DD-MM-YYYY)_____

☐ I do not require further testing or information al this time.

☐ Dased on the results provided, additional testing must be performed or additional information provided before stem cell collection can occur. Please provide additional comments below.

Comments:	
Transplant center:	
Transplant center contact person(s):	
Telephone number:	24-hour telephone number:
Transplant center representative (prinded name):	
Date (DD.MM.YYYY):	Signature: