Donor outcome

Report on donation procedure and up to 30 days after

TRANSPLANT CENTRE AND RECIPIENT IDENTIFICATION

EBMT CIC _____
(if known)

EBMT database number _____
(if known)

Center of HSCT: _____

Hospital/unit: _____

Unique Patient Number or Code …….

Initials: _____ _____(first name(s)_surname(s))

Date of birth: _____ ____ ____
yyyy mm dd

Date of HSCT: _____ ____ ____
yyyy mm dd

PRODUCT

☐ BM (Including collection of MSC)
☐ PBSC
☐ Both *(*BM and PBSC)
☐ Unstimulated leukapheresis
(e.g. donor lymphocytes (DLI), etc.)
☐ other, specify _____

DONOR DATA

Donor number/ID……

Global Registration Identifier for Donors
(GRID):_____

Donor signed Informed consent for data transmission to the EBMT Registry ☐
Compulsory, registrations will not be accepted without this item!
Initials: …… …… first name(s)_surname(s))

Relationship to recipient:
☐ syngeneic (identical twin)
☐ identical sibling/non identical twin
☐ other family member: ☐ matched
☐ unmatched
Describe relation _____
to the recipient *(aunt, uncle, first cousin, etc.)*

☐ unrelated donor:

Global Registration Identifier for Donors

(GRID):_____

Date of birth: _____ ____ ____
yyyy mm dd
Sex: ☐ male ☐ female
(at birth)

DONATION PROCEDURE

First day of this collection: _____ ___ ___
yyyy mm dd

COLLECTION DATA

EBMT Code (CIC): …….
(If known)
Collection center: ……...

Donor registry:
……..……..

Contact person: ……

Date of this report: _____ ____ ____
yyyy mm dd

Start date of donation procedure: _____ ____ ____
yyyy mm dd

Chronological Number of this donation procedure: __
If >1: Same recipient ☐ no ☐ yes
Centre of previous donation: ……
Date of previous donation: ____ ___ ___
yyyy mm dd

Was the product collection completed? ☐ no ☐ yes

Were haematopoietic growth factors used? ☐ no ☐ yes
(eg GCSF) if yes, specify……..

Were cell binding inhibitors used, ☐ no ☐ yes
(eg Plerixafor) if yes: specify……

Was erythropoietin used? ☐ no ☐ yes

Were other drugs used for mobilization? ☐ no ☐ yes

COMPLICATIONS
in temporal association with the donation procedure

➔ Report every serious adverse event occurring within the interval between start of the donation procedure and day 30 after the end of donation procedure with **ICD 10 Coding**
(see list in Appendix I of the manual)

Serious **A**dverse **E**vents (SAE/SAR): ☐ no ☐ yes ☐ unknown
if yes: ICD 10 Code: ___.__
Date of the SAE/SAR _____ ____ ____
yyyy mm dd
ICD 10 Code: ___.__
Date of the SAE/SAR _____ ____ ____
yyyy mm dd

REMINDER ➔ please report SAE/SAR to your National authority according to your regulations. **If donor is unrelated,** report also to **WMDA SEAR registry**

DONOR BEHAVIOUR

Would the donor donate again?
☐ no ☐ yes ☐ unknown
If no: reason: _____

Donor outcome

Long term follow up report after last donation procedure

(To be also used if reporting the death of a donor shortly after donation)

TRANSPLANT CENTRE AND RECIPIENT IDENTIFICATION

EBMT CIC _____*(if known)*

EBMT database number _____
(if known)

Center of HSCT: _____
Hospital/unit: _____
Unique Patient Number or Code …….

Initials: _____ _____(first name(s)_surname(s))

Date of birth: _____ ____ ____
yyyy mm dd

Date of HSCT: _____ ____ ____
yyyy mm dd

COLLECTION CENTRE IDENTIFICATION

EBMT Code (CIC): ……
(If known)

Collection center: …… .

Registry: ……

……

Contact person: ……..…

PRODUCT

☐ BM (Including collection of MSC)
☐ PBSC
☐ Both *(*BM and PBSC)
☐ Unstimulated leukapheresis
(e.g. donor lymphocytes (DLI), etc.)
☐ other, specify _____

DONOR DATA

Donor number/ID: ……

Global Registration Identifier for Donors (GRID):

_____

Initials: __ __ (first name(s)_surname(s))

Date of birth: _____ ____ ____
yyyy mm dd

Sex: ☐ male ☐ female *(at birth)*

FOLLOW UP OR DEATH REPORT

Date of last follow up or death: _____ ____ ___
yyyy mm dd

FU Report: __ month __ year

Date of this report: _____ ____ ____
yyyy mm dd

SAE/SAR SINCE LAST REPORT

MALIGNANCY

Hematological malignancy? ☐ no ☐ yes ☐ unknown

If yes: ICD 10 Code: ___.__ (see manual, list in Appendix I)

Confirmed by medical data ☐ no ☐ yes ☐ unknown

Date of the SAE/SAR _____ ____ ____
yyyy mm dd

Non-hematological malignancy? ☐ no ☐ yes ☐ unknown

if yes: ICD 10 Code: ___.__ (see manual, list in Appendix I)

Confirmed by medical data ☐ no ☐ yes ☐ unknown

Date of the SAE/SAR _____ ____ ____
yyyy mm dd

NON MALIGNANCY

Autoimmune disease? ☐ no ☐ yes ☐ unknown

if yes: ICD 10 Code: ___.__ (see manual, list in Appendix I)

Confirmed by medical data ☐ no ☐ yes ☐ unknown

Date of the SAE/SAR _____ ____ ____
yyyy mm dd

REMINDER ➔ **please** report SAE/SAR to your National authority according to your regulations. **If donor is unrelated,** report also to **WMDA SEAR registry**

DONOR STATUS ON THIS DATE

☐ Alive

☐ Dead: Donation related ☐ no ☐ yes ☐ unknown

ICD 10 code for main cause of death: ___.__
(*Select only one main cause)*
ICD 10 code(s) for contributory causes of death:
___.__ ___.__ ___.__
(See manual: list of ICD 10 codes in Appendix I)

Describe below the cause of death if necessary:

……

☐ Check here if donor lost to follow up

DONOR BEHAVIOUR

Would the donor donate again?
☐ no ☐ yes ☐ unknown

If no: reason: _____

Comments _____