Document Type	|	Form
Index Number	|	Registry 117
Version Number	|	1.0
Title	|	Donor Short Term Outcome
Author	|	Annelot van Amerongen
Authorised By	|	Annelot van Amerongen
Authorised On	|	22-Aug-2023
Release Date:		22-Aug-2023

DONOR OUTCOME
Donation procedure and day 30 follow-up

DONOR DATA

Donor weight at collection: _____ kg

Relationship to recipient:

☐ Related donor:

☐ HLA-identical sibling *(may include non-monozygotic twin)*		
☐ Syngeneic *(monozygotic twin)*		
☐ HLA-matched other relative	**Relationship to recipient:**	☐ First degree ☐ Third degree
☐ HLA-mismatched relative		☐ Second degree ☐ Fourth degree

☐ Unrelated donor

TRANSPLANT CENTER AND RECIPIENT IDENTIFICATION

EBMT Centre Identification Code (CIC): _____ *(of centre that performed the transplant)*

EBMT Centre name: _____ *(of centre that performed the transplant)*

EBMT Unique Identification Code (UIC): _____ *(only if donor was related to patient, or if donor was unrelated but the donation took place in the country of treatment)*
(patient number in EBMT database)

Patient ID: _____ *(only for unrelated patients)*

Hospital Unique Patient Number or code (UPN): _____ *(only if donor was related to patient, or if donor was unrelated but the donation took place in the country of treatment)*

Initials: _____ / _____ *(first name(s) / family name(s))*

Date of birth: _ _ _ _ / _ _ / _ _ *(YYYY/MM/DD)*

Date of treatment (HCT/CT): _ _ _ _ / _ _ / _ _ *(YYYY/MM/DD)*

COLLECTION CENTRE IDENTIFICATION

EBMT Centre Identification Code (CIC): _____
(if known)

Collection centre: _____

Donor registry: _____ *(only for unrelated donors)*

Contact person: _____

PRODUCT

Donated product:

- ☐ BM (including collection of MSC)
- ☐ PBSC
- ☐ Both, BM and PBSC
- ☐ Unstimulated leukapheresis (e.g. donor lymphocytes (DLI), etc.)
- ☐ Other; specify: _____

DONOR EVALUATION BEFORE DONATION

Date of evaluation: _ _ _ _ / _ _ / _ _ *(YYYY/MM/DD)*

Co-existing disease or organ impairment present at time of evaluation/donation:

☐ No

☐ Yes *(check & specify all that apply)*:

☐ Cardiovascular	ICD code: _____
☐ Pulmonary	ICD code: _____
☐ Gastrointestinal	ICD code: _____
☐ Genito-urinary	ICD code: _____
☐ Neurological	ICD code: _____
☐ Immune/autoimmune	ICD code: _____
☐ Infectious	ICD code: _____
☐ Haematological	ICD code: _____
☐ Oncological	ICD code: _____
☐ Psychological	ICD code: _____
☐ Other; specify: _____	ICD code: _____

ICD version used: _____

☐ Unknown

DONATION PROCEDURE

Collection date: _ _ _ _ / _ _ / _ _ *(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 this product collection completed?

☐ No
☐ Yes

Were haematopoietic growth factors used *(e.g. G-CSF)***?**

☐ No
☐ Yes; Product and brand name: _____ Date of first injection: _ _ _ _/_ _/_ _ *(YYYY/MM/DD)*

Total dose per injection: _____ µg/kg

Number of doses per day: ____

Total number of doses: _____

Were cell binding inhibitors used *(e.g. Plerixafor)***?**

☐ No
☐ Yes; specify: _____ Date of first injection: _ _ _ _/_ _/_ _ *(YYYY/MM/DD)*

Was erythropoietin used?

☐ No
☐ Yes; specify: _____ Date of first injection: _ _ _ _/_ _/_ _ *(YYYY/MM/DD)*

Were other drugs used for mobilisation?

☐ No
☐ Yes; specify: _____ Date of first injection: _ _ _ _/_ _/_ _ *(YYYY/MM/DD)*

Apheresis collection:

Number of aphereses performed: _____

Collection technique: ☐ By peripheral veins ☐ By central venous catheter

DONATION PROCEDURE continued

Bone Marrow collection:

Anaesthesia: ☐ General ☐ Epidural/spinal ☐ Local

Autologous blood donation prior to collection? ☐ No ☐ Yes

Was autologous blood re-transfused? ☐ No ☐ Yes

COMPLICATIONS
in temporal association with the donation procedure

Please, 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 Coding.

Serious adverse events observed:

☐ No

☐ Yes :

ICD code: _____ Specify:_____ Onset date: _ _ _ _ / _ _ / _ _ *(YYYY/MM/DD)*

ICD code: _____ Specify:_____ Onset date: _ _ _ _ / _ _ / _ _ *(YYYY/MM/DD)*

ICD code: _____ Specify:_____ Onset date: _ _ _ _ / _ _ / _ _ *(YYYY/MM/DD)*

ICD code: _____ Specify:_____ Onset date: _ _ _ _ / _ _ / _ _ *(YYYY/MM/DD)*

ICD code: _____ Specify:_____ Onset date: _ _ _ _ / _ _ / _ _ *(YYYY/MM/DD)*

ICD version used: _____

☐ Unknown

Reminder: *please report SAE/SAR to your National authority according to your national regulations. If donor is unrelated, report also to WMDA SPEAR registry.*

DONOR BEHAVIOUR

Would the donor donate again?

☐ No: Reason: _____

☐ Yes

☐ Unknown