

FREE TYPING PROGRAM FOR RELATED DONORS

RELATED PATIENT INFORMATION

First Name:	Last Name:	
Date of Birth (DD-MM-YYYY):		
HLA data of patient attached	yes	no, will follow asap

CONTACT AT TRANSPLANT CENTER

Results should be sent to	Physician	BMT Coordinator
Title:	First Name:	Last Name:
Address:		
City:	Country:	Zip code:
E-mail:		
Tel.:		

Person completing form:	Signature:	Date (DD-MM-YYYY):
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RELATED DONOR INFORMATION (please provide as accurate and detailed information as possible)

First Name:	Last Name:	
Address:		
City:	Country:	Zip code:
E-mail:	Mobile:	
Date of Birth (DD-MM-YYYY):	Relationship to patient:	
English speaking donor:	yes	no
If <u>no</u>, please provide English speaking contact person for organisational reasons		
Name:	Relationship to donor:	
Tel:	E-mail:	

COLLECTION OF DONOR

If donor is a match, how do you plan to organize the collection?
Stem cells will be collected in our center
We are interested in DKMS coordinating the collection (for more information please contact familydonors@dkms.org)