DKMS Donor Center gGmbH
Kressbach 1
72072 Tübingen, **Germany**

DKMS Stem Cell Bank gGmbH
Enderstraße 94, Building C
01277 Dresden, Germany

Formal Request for Adult Donor Cryopreserved Unit Shipment

PATIENT DATA

Patient name/initials:			**Date of birth (DD.MM.YYYY):**
Patient ID: (assigned by patient registry)	**Patient ID:** (assigned by donor registry)	**Patient ID:** (EMDIS ID)	**Patient registry:**
Gender:	**CMV:**	**ABO/Rh D/Kell:**	**Weight (kg):**

PRODUCT DATA

PIS: (product identification sequence)	**Stem cell bank name:** DKMS Stem Cell Bank (SCB)

DONOR DATA

Original donor GRID:		
Gender:	**CMV:**	**ABO/Rh D/Kell:**

TRANSPLANT CENTER AND PATIENT INFORMATION

☐ **transplant center is also shipping address**
☐ **transplant center is also invoice address**

Transplant center name:	**Contact name:**
Street address:	**Phone:**
City, ZIP code:	**E-mail:**
Country:	**Fax:**
Current diagnosis and disease stage:	
Start of conditioning: (DD.MM.YYYY)	**Conditioning regimen:** ☐ Myeloablative ☐ Reduced intensity
Please attach copy of patient's HLA lab report:	☐ Attached

SHIPMENT INFORMATION (if different from transplant center address)

Institution name:	**Attention/Contact name:**
Street address:	**Phone:**
City, ZIP code:	**24-hour phone:**
Country:	**E-mail:**

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PATIENT/DONOR/PRODUCT IDs

Patient ID: (assigned by patient registry)	**Patient ID:** (assigned by donor registry)	**Patient ID:** (EMDIS ID)	**Patient registry:**
Donor GRID:			
PIS: (product identification sequence)		**Stem cell bank name:** DKMS Stem Cell Bank (SCB)	

INVOICE INFORMATION (if different from transplant center address)

Institution name:	**Contact name:**
Street address:	**Phone:**
City, ZIP code:	**E-mail:**
Country:	**Fax:**

PROPOSED DATES (DD.MM.YYYY)

Shipment date:	**Infusion date:**
The minimum amount of time after receipt of the workup until the product will be sent out to the requesting party is 3 days due to internal quality controls.	

ADDITIONAL SAMPLES

Should the DKMS Stem Cell Bank provide residual cellular samples if available?

☐ Yes ☐ No

If yes, which samples would you like to request?

☐ 1x1 ml retain sample of transplant ☐ DNA ☐ 1x2 ml plasma

COURIER INFORMATION

☐ Courier and cryoshipper organized by transplant center

☐ Courier and cryoshipper organized by DKMS Stem Cell Bank *(additional costs will apply for rental)*

☐ Courier organized by transplant center, cryoshipper organized by DKMS Stem Cell Bank *(additional costs will apply for rental)*

TRANSPLANT HISTORY

In case the requested adult donor cryopreserved unit is a second transplant, please attach a filled transplant history form (e.g. WMDA Form F20) of the previous transplant history to this request.

Is transplant used for second transplant? ☐ Yes ☐ No

If yes, please attach the transplant history form ☐ Attached

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PATIENT/DONOR/PRODUCT IDs

Patient ID: (assigned by patient registry)	**Patient ID:** (assigned by donor registry)	**Patient ID:** (EMDIS ID)	**Patient registry:**
Donor GRID:			
PIS: (product identification sequence)		**Stem cell bank name:** DKMS Stem Cell Bank (SCB)	

Regarding the adult donor cryopreserved unit above, I verify that the ABO and Rh D type, degree of HLA match, total nucleated cell dose, compatibility testing results, and infectious disease results are acceptable to proceed with stem cell product shipment for the above-mentioned patient. In addition, the necessary procedures are in place for the receipt, storage, and thawing, processing, infusion of stem cell products at the transplant center.

Form completed by (printed name):	Date (DD.MM.YYYY):	Signature:
Responsible transplant physician (printed name):	Date (DD.MM.YYYY):	Signature:

COMMENTS

Please send via e-mail to workup@dkms.de.