

## Formal Request for Adult Donor Cryopreserved Unit Shipment

### PATIENT DATA

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

### PRODUCT DATA

|                                           |                                                |
|-------------------------------------------|------------------------------------------------|
| PIS:<br>(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:<br>(DD.MM.YYYY)          | Conditioning regimen: <input type="checkbox"/> Myeloablative <input type="checkbox"/> Reduced intensity |                                   |  |
| Please attach copy of patient's HLA lab report: |                                                                                                         | <input type="checkbox"/> 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

|                                                      |                                                    |                                                       |                          |
|------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------|--------------------------|
| <b>Patient ID:</b><br>(assigned by patient registry) | <b>Patient ID:</b><br>(assigned by donor registry) | <b>Patient ID:</b><br>(EMDIS ID)                      | <b>Patient registry:</b> |
| <b>Donor GRID:</b>                                   |                                                    |                                                       |                          |
| <b>PIS:</b><br>(product identification sequence)     |                                                    | <b>Stem cell bank name:</b> DKMS Stem Cell Bank (SCB) |                          |

### INVOICE INFORMATION (if different from transplant center address)

|                          |                      |
|--------------------------|----------------------|
| <b>Institution name:</b> | <b>Contact name:</b> |
| <b>Street address:</b>   | <b>Phone:</b>        |
| <b>City, ZIP code:</b>   | <b>E-mail:</b>       |
| <b>Country:</b>          | <b>Fax:</b>          |

### PROPOSED DATES (DD.MM.YYYY)

|                                                                                                                                                               |                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|
| <b>Shipment date:</b>                                                                                                                                         | <b>Infusion date:</b> |
| 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

|                                                                                                                                                                                                                                                                                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Should the DKMS Stem Cell Bank provide residual cellular samples if available?</b></p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>If yes, which samples would you like to request?</p> <p><input type="checkbox"/> 1x1 ml retain sample of transplant   <input type="checkbox"/> DNA   <input type="checkbox"/> 1x2 ml plasma</p> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

### COURIER INFORMATION

|                                                                                                                                                                                                                                                                                                                                                                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><input type="checkbox"/> Courier and cryoshipper organized by transplant center</p> <p><input type="checkbox"/> Courier and cryoshipper organized by DKMS Stem Cell Bank <i>(additional costs will apply for rental)</i></p> <p><input type="checkbox"/> Courier organized by transplant center, cryoshipper organized by DKMS Stem Cell Bank <i>(additional costs will apply for rental)</i></p> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

### TRANSPLANT HISTORY

|                                                                                                                                                                                                                                                                                                                                                                                                                        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>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.</p> <p>Is transplant used for second transplant?   <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>If yes, please attach the transplant history form   <input type="checkbox"/> Attached</p> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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### PATIENT/DONOR/PRODUCT IDS

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|------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------|--------------------------|
| <b>Patient ID:</b><br>(assigned by patient registry) | <b>Patient ID:</b><br>(assigned by donor registry) | <b>Patient ID:</b><br>(EMDIS ID)                      | <b>Patient registry:</b> |
| <b>Donor GRID:</b>                                   |                                                    |                                                       |                          |
| <b>PIS:</b><br>(product identification sequence)     |                                                    | <b>Stem cell bank name:</b> 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

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|--|
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Please send via e-mail to [workup@dkmsregistry.org](mailto:workup@dkmsregistry.org).