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FORMAL SEARCH REQUEST FOR MATCHED UNRELATED DONOR

This form is to be submitted to the National Stem Cell Coordinating Centre through fax (603) 26132674 or email to nsccc@moh.gov.my, address: Jalan Tun Razak 50400 Kuala Lumpur, Malaysia. Please fill in patient ID (IC/MRN) on every page of this form.

Date of submission :

Section 1: General

Name of patient :

IC : MRN :

NSCCC donor ID :

:

:

Activating work up process? ☐ Yes ☐ No

Has the patient undergone previous transplant? ☐ Yes ☐ No

If yes please indicate type of transplant and date :

:

Preferred stem cell :

☐ Bone marrow
☐ PBSC
☐ Lymphocytes
☐ Others:……..

Patient ID (IC/MRN) | |

Proposed collection dates

First choice	:
Second choice	:
Third choice	:

How many days is the patient's preparative regiment? ☐ Days

What is the latest date the transplant centre needs to receive donor clearance in order to meet the first choice collection dates(s)? ☐

Day(s) of the week transplant centre prefers for collection?

- ☐ Monday
- ☐ Tuesday
- ☐ Wednesday
- ☐ Thursday
- ☐ Friday

Patient ID (IC/MRN)

Section 2: Patient clinical information

Blood type	
Weight	
Height	

Preparative regiments will be ☐ Myeloablative ☐ Reduced intensity

List of drugs and/ or TBI schedule:

Excluding plasma/ red cell depletion, the stem cell product will be

☐ Un-manipulated
☐ T-cell depleted
☐ CD 34+ selected
☐ Others ……..

Classify workup based on patient clinical condition

☐ Urgent
☐ Standard

Patient ID (IC/MRN) ☐

Patient diagnosis and staging

☐ ALL ☐ With Philadelphia ☐ CR1 ☐ CR2 ☐ > CR3

☐ Without Philadelphia ☐ Not in CR …….% of blast cells in BM

☐ AML ☐ De novo AML except APL ☐ CR1 ☐ CR2 ☐ > CR3

☐ De novo APL ☐ Not in CR …. % of blast cells in BM

☐ Secondary AML

Specify original disease: …….

☐ CML ☐ Chronic phase

☐ Accelerated phase

☐ Blast crisis

☐ Other leukaemia, specify:…….

☐ Hodgkin's Lymphoma

☐ Non-Hodgkin's Lymphoma

☐ Multiple myeloma

☐ Other plasma cell disorder, specify:…….

☐ Other cancer not specified above, specify:……..

☐ Myelodysplasia (MDS)/ Myeloproliferative disorder (MPD), specify……

☐ Defective haemopoeisis

☐ Immune deficiency disorder, specify:……..

☐ Metabolic storage disease, specify:……..

☐ Histiocystic disease, specify:……..

☐ Other disease not specify above, specify:……..

Patient ID (IC/MRN)

Section 3: Physician Verification

Other additional comments:

I hereby request that the potential matched unrelated donor, in reference to the NSCCC donor ID as specified in this form, to be further assessed and evaluated for potential HSCT for this patient.

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(signature of the physician)

Name : .....

IC : .....

MMC no. : .....

Designation : .....

Institution : .....