佛教慈濟骨髓幹細胞中心
Buddhist Tzu Chi Stem Cells Center
Work-up Request Form

General Information
Date :
Recipient BTCSCC ID : Donor GRID：
Recipient ID Number :
Recipient Name :

Activating work-up request? ☐ Yes ☐ No
Has the patient undergone a previous stem cell transplant? ☐ No ☐ Yes → Indicate Type of transplant and date performed _____

Preferred stem cell ☐ Bone Marrow ☐ PBSC ☐ Lymphocyte ☐ Others _____
Proposed collection date(s)
First Choice _____ Second Choice _____ Third Choice _____
- How many days is this patient's preparative regimen? _____ Days
- What is the latest date the transplant center needs to receive donor clearance in order to meet the first choice collection date(s)?_____
- Day(s) of the week transplant center prefers a stem cell product(s) collected：
  ☐Tuesday ☐Wednesday ☐Thursday ☐Friday

Patient Clinical Condition
(Provide relevant information that can assist in the counselling of the potential donor)

1. Blood type _____ Weight _____ kg Height _____ cm
2. Patient current diagnosis & disease stage (Please fill out Page. 2.)
3. The patient's preparative regimen will be ☐ Myeloablative ☐ Reduced Intensity
   List drugs and/ or TBI schedule _____
   _____
4. Excluding plasma/ red cell depletion, the stem cell product will be
   ☐ Un-manipulated ☐ T-cell depleted ☐ CD34+ selected ☐ Other _____
5. Classify workup based on patient clinical condition ☐ Urgent ☐ Standard

Transplant Center _____
Referring Physician Signature_____
Name in Print _____ Date ____/____/____(yyyy/mm/dd)

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707 Sec. 3, Chung Yang Road, Hualien, Taiwan 970, R.O.C.

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Patient Current Diagnosis and Disease Stage

☐ 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 Leukemia Specify _____		☐ CR ☐ Not in CR
☐ Hodgkin's Lymphoma		☐ CR ☐ Not in CR
☐ Non-Hodgkin's Lymphoma		☐ CR ☐ Not in CR
☐ Plasma Cell Disorder Multiple Myeloma ☐ Other Plasma Cell Disorder Specify _____		
☐ Other Cancer Not in Above Specify _____ ☐ CR ☐ Not in CR		
☐ Myelodysplasia(MDS) / Myeloproliferative Disorder(MPD) Specify _____		
☐ Defective Hemopoiesis		☐ Aplastic anemia ☐ Thalassemia ☐ Other, specify _____
☐ Immune Deficiency Disorder Specify _____		
☐ Metabolic Storage Disease Specify _____		
☐ Histiocytic Disorders Specify _____		
☐ Other Disease Not in Above Specify _____		

BTCSCC Medical Director Approval _____ Date ____/____/____(yyyy/mm/dd)

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