**CONTACT DETAILS DONOR CENTER**

Address of donor center

Doctor’s surname and first name

**DONOR DETAILS**

*Donor’s surname and first name: …………………………………………………………………………*

*Date of birth: Blood group (if known):*

*National register number/Identity card number: Ethnicity:*

*Donor's full address:*

*Donor’s contact details:*

*Tel. (home):………………………………………Tel. (work):………………………………………….*

*Mobile:*

*E-mail:*

*Recruitment:*

*Via entourage / association / website / blood donor info / press / unknown / other:*

*I:* [ ]  *wish to be invited as a blood, plasma or platelet donor;*

 [ ]  *DO NOT* *wish to be invited as a blood, plasma or platelet donor.*

 [ ]  *not applicable*.

Your signature below confirms that you have read this document. Please indicate whether you agree or disagree with each of the statements.

|  |  |  |
| --- | --- | --- |
| I wish to register as a voluntary stem cell donor for a patient who is not related to me and does not have a suitable donor in his/her family. I consent to this voluntarily and of my own volition.  | [ ]  YES | [ ]  NO |
| I have read and understood the information letter for registration of voluntary stem cell donors.  | [ ]  YES | [ ]  NO |
| I have had the opportunity to ask questions and am satisfied with the answers received. | [ ]  YES | [ ]  NO |
| I have received sufficient information about the goals, methods and potential risks involved in the collection of stem cells.  | [ ]  YES | [ ]  NO |
| I am aware that this collection can occur via blood or bone marrow. | [ ]  YES | [ ]  NO |
| I have been satisfactorily informed about G-CSF stimulation and anaesthesia, and their possible side-effects. | [ ]  YES | [ ]  NO |
| I give my consent, if insufficient stem cells appear in the blood after administration of G-CSF, to collection of bone marrow from me under anaesthetic in the operating room. | [ ]  YES | [ ]  NO |
| I know that a hospital admission lasting 36 to 48 hours may be necessary in the case of anaesthesia. | [ ]  YES | [ ]  NO |
| I agree to tissue-typing being carried out on my blood and that the data generated will be stored in the national database of voluntary stem cell donors (MDPB-R).  | [ ]  YES | [ ]  NO |
| I give consent to the registry and the donor center to use my data in an anonymous way in the search for a suitable stem cell donor, for both Belgian and international patients. | [ ]  YES | [ ]  NO |
| I give consent for the collection, input and processing of the data relating to me, by persons bound by professional secrecy. This data will remain strictly confidential and it will be used for scientific purposes in an anonymous format. | [ ]  YES | [ ]  NO |
| I give consent for the data from my tissue-typing to be used in the event that the blood transfusion center needs tissue-identical blood platelets for a patient. | [ ]  YES | [ ]  NO |
| If I am selected with a view to a donation for a patient, I know that additional tests will be carried out to determine our HLA compatibility and it will be determined whether I am infected with certain viruses.  | [ ]  YES | [ ]  NO |
| I am aware that, a few weeks before the collection of the stem cells, a doctor will carry out a medical examination, consisting of medical history, clinical examination and a blood sample, which will be used for blood tests to rule out infection. | [ ]  YES | [ ]  NO |
| I know about the existence of infectious diseases (HIV, hepatitis) and that they can be transmitted from donor to patient. | [ ]  YES | [ ]  NO |
| I know that I will be informed if the result is abnormal, and that all results will be notified to the transplant doctor and the patient.  | [ ]  YES | [ ]  NO |
| I know that I have the right to withdraw 'at any time' my consent to donate stem cells, without having to give a reason. I am aware that such a decision in the days before the collection may be fatal for the patient who is the intended recipient of the stem cells. | [ ]  YES | [ ]  NO |
| In the event of definitive or temporary withdrawal of my candidature, or in case of a change of address, I undertake to inform the donor center whose address is given above. | [ ]  YES | [ ]  NO |
| I am aware that in a minority of cases, a second collection (of stem cells or lymphocytes) may be requested, a few weeks or months or years after the first collection.  | [ ]  YES | [ ]  NO |
| I know that stem cells will also be used in the future for other applications than stem cell transplants, including in regenerative medicine, and that a separate consent form will be necessary for that. | [ ]  YES | [ ]  NO |
| The costs of registration and tissue-typing are paid entirely by the laboratory.  | [ ]  YES | [ ]  NO |
| I know that I will not receive any financial remuneration for donating stem cells or lymphocytes. | [ ]  YES | [ ]  NO |
| I know that for every stem cell or lymphocyte donor, insurance is taken out to cover any physical harm that is a consequence of donation. | [ ]  YES | [ ]  NO |
| I am aware that information about the patient for whom I am donating cells may only be disclosed anonymously after the consent of the Belgian Registry, the patient him/herself and the transplantation center. | [ ]  YES | [ ]  NO |
| I know that the cells may be frozen in exceptional circumstances, and that those cells may be stored for as long as there is still an indication for administering them subsequently to the patient. If there is no longer any indication, then these frozen cells will be destroyed without me being informed. | [ ]  YES | [ ]  NO |
| I have been informed that 1 week, 1 month and 5 years after the stem cell donation, I will be contacted to find out about my state of health and for a possible blood collection. | [ ]  YES | [ ]  NO |
| I also know that when I reach 60 years of age, I will automatically be removed from the register. | [ ]  YES | [ ]  NO |

I hereby declare that I have read this document and received sufficient information:

[ ]  I have received a copy of the general donor information letter.

[ ]  I have received a copy of the information letter about donor expenses and anonymous communication.

[ ]  I have received a copy of this consent form.

***Signature of the donor Signature of the doctor***

*Place: Place:*

*Date: Date:*

Completed in 2 originals:

* 1 for the candidate donor
* 1 for the records.