The undersigned (surname, first name) .......................... gives his/her informed, deliberate and free consent for the administration of G-CSF and the collection of stem cells from the blood for the treatment of a patient with an allogeneic stem cell transplant. The undersigned confirms that he/she has read this document, has had the opportunity to ask questions and consents to the collection, storage and use of the stem cells.

Please also tick the boxes below to indicate whether you agree or disagree to the storage and use of stem cells for scientific research.

|  |  |  |
| --- | --- | --- |
| I have carefully read and understood the written information about donation of stem cells from blood or bone marrow, and have received satisfactory answers to my questions. | YES | NO |
| I know that I will not receive any financial remuneration for donating stem cells. | YES | NO |
| I know that all the costs entailed in the collection of stem cells will be paid by the National Institute for Sickness and Invalidity Insurance or the foreign registry of the acceptor of the stem cells. | YES | NO |
| I have been satisfactorily informed about G-CSF stimulation and anaesthesia, and their possible side-effects. | YES | NO |
| I have been informed about the collection procedure. I have been told what a stem cell collection is, and the purpose and the nature of the stem cell collection are clear to me. | YES | NO |
| I have been told how the collection will be carried out. | YES | NO |
| The risks involved in this type of collection have been discussed with me. | YES | NO |
| I agree that the doctors will use the discussed harvesting procedure. | YES | NO |
| I agree that the doctors will store the donated stem cells and use them for an allogeneic stem cell transplant. | YES | NO |
| I know that during the donor approval process, laboratory tests will be carried out, and I will be informed of any abnormal result. Abnormal test results will also be notified to the transplant doctor and to the patient. | YES | NO |
| I give my consent, if insufficient stem cells appear in the blood after administration of G-CSF, to collect bone marrow under anaesthesia in the operating room. | YES | NO |
| I give my consent, if it is impossible to place a catheter in my forearm:   * to place a catheter in the groin veins * to place a catheter in the neck veins | YES  YES | NO  NO |
| I have the right to withdraw 'at any time' my consent to donate stem cells and to their use, before the body tissue has undergone any treatment. I do not have to give a reason for this decision. I am aware that such a decision may be fatal for the patient who is the intended recipient of the stem cells. | YES | NO |
| If the transplant is not a complete success or in the event of complications, I give my consent to donate lymphocytes. | YES | NO |
| I agree that my coded data about my stem cell donation will be given to national and international authorities working in the field of stem cell transplants. | YES | NO |
| I know that a proportion of the cells collected may be frozen. This proportion can only be used for subsequent administration to the patient. | YES | NO |
| I give my consent to the attending physician of the transplant patient to retain my donated stem cells or other hematopoietic cells if the patient should die or if his/her state of health no longer allows or warrants their administration. Among other things, this implies possible destruction of these cells. | YES | NO |
| If the doctor in charge does not consider continued storage useful, the remaining stem cells shall be destroyed. I will not be informed about this. | YES | NO |
| I allow the stem cells that may be destroyed to still be stored and only used for scientific research. Any scientific research shall be submitted in every case to the Medical Ethics Committee. | YES | NO |
| The donor details are recorded in a database. I know that the donor doctor is bound by professional secrecy and that my details will be treated as confidential. | YES | NO |
| I know that the medical data concerning the donation will be consulted by the transplant doctor and that if it is relevant for transplants, it will be passed on to the patient. | YES | NO |
| I have had the opportunity to ask questions about anything that was unclear to me, and I am satisfied with the answers given to my questions. | 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 a copy of the information letter about donor expenses and anonymous communication.

I have received a copy of this consent form.

***Donor's surname and first name Doctor's surname and first name***

*National register number/Identity card number:*

*Signature Signature*

*Place: Place:*

*Date: Date:*

***Witness's surname and first name***

*Signature*

*Place:*

*Date:*

Completed in 2 originals:

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