The undersigned (surname, first name) ………………………………………………….……………..………. is informed, aware and freely consents to the donation of lymphocytes 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 lymphocytes. Please tick all the boxes below to indicate agreement.

|  |  |  |
| --- | --- | --- |
| I have understood the information and have received satisfactory answers to my questions. | YES | NO |
| I know that I will not receive any financial remuneration for donating lymphocytes. | YES | NO |
| I have been told what lymphocytes are. The purpose and nature of the collection is clear to me. | YES | NO |
| For female donors: I know that I am advised to avoid pregnancy and that I need to undergo a pregnancy test before the collection. | 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 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 * to place a catheter in the chest veins | YES  YES  YES | NO  NO  NO |
| I agree that the doctors will use the donated lymphocytes for a donor lymphocyte infusion and possibly store them. | YES | NO |
| I can inspect the test results, such as HIV. | YES | NO |
| I know that a proportion of the collected cells may be frozen. This proportion can only be used for later administration to the patient. | YES | NO |
| If the patient dies, these donor lymphocytes will be destroyed. | 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 |
| The donor details are recorded in a database. I know that the doctor of the donor centre is bound by professional secrecy and that my details will be treated as confidential. | YES | NO |
| This consent is given voluntarily and deliberately, after being informed. | YES | NO |
| I know that I can withdraw my consent to this procedure as long as there has been no processing of the lymphocytes and as long as no actions have been taken to prepare the patient for the administration of lymphocytes. | YES | NO |

|  |  |  |
| --- | --- | --- |
| I give my express consent for the use of my donation, if it is not suitable for transfusion, or of residual fractions or samples from my donation, under the aforementioned conditions, in scientific research\* and/or for validation or educational purposes.  \* Once this scientific research has commenced, this consent can no longer be withdrawn. | YES | NO |

You also acknowledge through this document that you have read and understood the data policy applicable to the processing of your personal data in respect of your donation of stem cells from blood or bone marrow, and that you are aware that your personal data will be passed on in encrypted form to the World Marrow Donor Association and other foreign centres active in the field of stem cell transplants. You may register your preferences with regard to the processing of your personal data below.

I do **not** wish to be invited for additional research or innovative medical purposes such as regenerative medicine & immunotherapy.

I do **not** wish to be contacted for the donation of blood, platelets and/or plasma that may be required for the treatment of a specific patient.

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

I have received a copy of the general donor information sheet, including the data policy, and I have read and understood its contents.

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

I have received a copy of this consent form.

*National register number/Identity card number:*

|  |  |
| --- | --- |
| *Surname and first name of the* ***donor****:* | |
| *Signature:* | *Place:*  *Date:* |

I hereby declare that:

the identity of the donor has been verified.

|  |  |
| --- | --- |
| *Surname and first name of the* ***doctor****:* | |
| *Signature:* | *Place:*  *Date:* |

|  |  |
| --- | --- |
| *Surname and first name of the* ***witness****:* | |
| *Signature:* | *Place:*  *Date:* |

Completed in 2 originals:

* 1 for the candidate donor
* 1 for the records