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 (RIZIV/INAMI/LIKIV) 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 |
| For female donors: I know that I need to undergo a pregnancy test and that I am advised to avoid pregnancy before G-CSF stimulation, before the patient preparation and 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 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 there are laboratory tests that are passed on to the transplant physician at the transplant center. This is done anonymously. | YES | NO |
| I know that I will be notified of any abnormal results of these laboratory tests. | 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 * to place a catheter in the chest veins | YES  YES  YES | NO  NO  NO |

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| --- | --- | --- |
| 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 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 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 |
| 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 |

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.