Sampling Form MRD 1

Study Number: _ _ _ - _ _ _ **Date of birth:** _ _ / _ _ / _ _ _ _ (dd/mm/yyyy)

Sex: male / female **Date of acquisition:**_ _ / _ _ / _ _ _ _(dd/mm/yyyy)

Center of acquisition: _____**City (country):** _____

Responsible Local Investigator: …….. Email: …….

Patient Risk Group Classification (remission status after cycle 1 incorporated)

☐ Good ☐Intermediate ☐Poor ☐ Very poor

Check off	**Sampling time (examples)**	**Central Laboratory**
☐	**At diagnosis**	10 ml heparin BM (*) 10 ml heparin PB
☐	**After cycle 1**	10 ml heparin BM
☐	**After cycle 2**	10 ml heparin BM
☐	**After cycle 3 or auto HSCT graft**	10 ml heparin BM
☐	**Sample of Auto HSCT graft**	1 ml of HPC, Apheresis product
☐	**Sample before AlloHSCT**	10 ml heparin BM
☐	**3 months after AlloHSCT**	10 ml heparin BM
☐	**6 months after cycle3 or 6 months after AlloHSCT**	10 ml heparin BM
☐	**At relapse** (*	10 ml heparin BM (*) 10 ml heparin PB

* in case of dry tap, please send ***an extra 10 ml*** heparin PB
BM is bone marrow, PB is peripheral blood; HPC is Human Progenitor Cells.

After completing this form, please make a copy and send the samples accompanied by the form to:

Center:
Department:
Address:
City, Country:
Telephone contact person:
E-mail address:

Comments: _____
Name responsible physician: _____

Signature:_____