XPRESS URGENT CARE

NMDP ** VIP**

↓

Xpress Corporate Care (XCC) Account

- No authorization required
- Print all forms on Internal Web Page
- All pages completed and scanned in chart

DO NOT COLLECT PAYMENT AT TIME OF SERVICE.

↓

Demographics –

✓ MNDP must be added under the Insurance Tab in demographics.

NOTE: MUST scan In ID.

↓

Once you click "OK" on the appt, you will be redirected to a new screen.
NMDP PLATFORM!

↓

Next, you will select "Service(s)" tab on the left top corner of the NMDP appt screen. All the authorized services for that employer will become available!

****Select all services****.

↓

DO NOT COLLECT ANY PAYMENT

Billing note to say: BILL TO NMDR

Once the services are selected, there is a "total" at the bottom that will give you the correct total of $947.

↓

Confirm all forms are completely filled out from the MA side and scan all of them in

<u>***VIP***</u>

<u>*PATIENT NEEDS TO BE BROUGHT BACK TO A PATIENT ROOM IMEDIATELY UPON ARRIVAL TO***</u>**
<u>*COMPLETE ALL PAPERWORK***</u>**

<u>NMDP</u>

(NATIONAL MARROW DONOR PROGRAM)

ALSO DBA: BE THE MATCH, ONE BLOOD

<u>FRONT DESK</u>

- NO AUTHORATION REQUIRED
- SCAN IN PT ID
- PRINT ALL FORMS AND HAVE FULLY COMPLETED
- DO NOT COLLECT, WILL BE BILLED FOR SERVICES
- INSURANCE TO BE NMDP

PRICING IS SIMILAR TO OCCHEALTH PLATFORM

CHECK ALL SERVICES TO BE PERFORMED WHICH WILL BE ALL
IN THE PACKAGE/SERVICES TAB
TOTAL SHOULD BE $947

ACTION MUST BE SENT TO JODI WHEN THE PT IS CHECKED IN

<u>MA</u>

- SEND LABS **STAT** TO QUEST
- NO MORE THEN 3 DAYS FOR RESULTS
- MAKE SURE ALL CHECKLISTS ARE COMPLETED BEFORE PT LEAVES

NATIONAL MARROW DONOR PROGRAM® BE THE MATCH®

Venous Assessment Worksheet

Donor Name: ____

GRID: ______________________

The venous assessment worksheet is intended for use by health care providers who perform an assessment of a peripheral blood stem cell donor's venous access prior to their collection.

Preparation for Vein Assessment:

1. After cleansing the hands, apply tourniquet or blood pressure cuff to arm. Have donor pump fist or squeeze a rubber ball (or other object) prior to palpating veins.
2. Assess the antecubital veins (cephalic, basilic, and median cubital) for the draw needle (16-17 gauge). Ideally, placement of the return needle (18 gauge) will allow the donor to have one hand free for the duration of the apheresis procedure.
3. Rate the veins according to the following system:
   - **Good:** Well supported, large diameter; should not pose a challenge to the phlebotomist
   - **Fair:** Should be able to support the pressure exerted by the apheresis procedure and large enough for the large bore needle; may need a more experienced phlebotomist to perform the venipuncture
   - **Poor:** Poorly supported, small diameter; difficult for most phlebotomists to successfully perform a venipuncture

Vein Assessment: (check appropriate boxes)

LEFT	Good	Fair	Poor	RIGHT	Good	Fair	Poor
Basilic	○	○	○	Basilic	○	○	○
Median Cubital	○	○	○	Median Cubital	○	○	○
Cephalic	○	○	○	Cephalic	○	○	○
Forearm	○	○	○	Forearm	○	○	○
Wrist	○	○	○	Wrist	○	○	○
Hand	○	○	○	Hand	○	○	○

Central line placement recommended: ○ Yes ○ No

Comments:

Assessment Performed by:	Name	Title
Organization:	Facility Name	Date

Please Return Completed Document to:

______________________ ______________ ______________________

Acceptance Letter for Third-Party Physical Exam Providers

Thank you for agreeing to perform Physical Examinations on potential hematopoietic stem cell donors. The examination is to identify medical conditions that might put a donor at increased risk in donating or that could pose a risk to the recipient of the donated cells.

By agreeing to perform the Physical Examinations, you are confirming that a physician or a supervised advanced-level practitioner (NP, ARNP or PA-C), appropriately licensed and insured in your jurisdiction, will perform requested elements of a Physical Examination for each potential donor. You will email or fax us results of each Physical Examination as soon as possible, and no more than 3 days after the exam.

We will pay for these services within 30-45 days of receipt of your invoice, up to the stated total allowable amount (see enclosed Billing Instructions & Fee Schedule). Our donors are unpaid, and we want to ensure they do not receive medical bills associated with the donation process.

Initial: ________ I have instructed our billing department that services provided for NMDP/Be The Match donors will be billed to NMDP/Be The Match as noted in the Billing Instructions & Fee Schedule.

Individually Identifying Data will be provided to you for the exam. That may include names, contact information, identification numbers, birthdate, gender, and other confidential information. You must maintain that data in compliance with applicable federal and state requirements, including HIPAA and its regulations. You will use it only for the Physical Examination or for your or other third-party services related to that exam. You will not disclose that data to any individual or entity without written approval. If a breach discloses any of the data, you must notify us as soon as possible, by phone and e-mail, and work with us in responding to the data loss.

This letter must be completed, initialed, signed, and returned via fax/email <u>before</u> conducting Physical Examinations.

This letter will remain in effect for one calendar year from date of signature.

Practice Name:			
Mailing Address:			
City:		State:	Zip Code:
Telephone:		Fax Number:	
Primary Contact & Email:			

______________________________ ______________________________

Printed Name **Signature**

______________________________ ______________________________

Title **Date**

Please return the signed letter by fax ____________ **or email** ________________

BE THE MATCH

Donor Name: ______________________________

GRID: ____________________

ADDENDUM TO PHYSICAL EXAMINATION:
Assessment for Physical Evidence or Risk for Communicable Diseases

To minimize transmission of disease, all potential stem cell donors must be assessed for physical evidence or risk for relevant communicable diseases.* Diseases include West Nile virus, HIV-1/2, hepatitis B, hepatitis C, vaccinia virus infection, HTLV I/II, Chagas, Creutzfeldt-Jakob disease (CJD), variant CJD, sepsis, syphilis, and Zika virus.

Examining medical professional: complete Sections 1-3.
Donor Center Medical Director or designee: complete Section 4.

IMPORTANT: This document must be completed for all potential stem cell donors.

SECTION 1 General Examination Findings — To be completed for all potential donors

- *Review physical evidence or risk for communicable diseases as listed below.*
- *Mark YES or NO to indicate if physical evidence or risk was not or was present upon general exam. Explain findings below.*

A. Nonmedical percutaneous drug use such as needle tracks including examination of tattoos, which may be covering needle tracks

B. Tattooing performed ***in preceding 12 months***

If present, note **specific** date(s): ______________________________ (MM/DD/YYYY)

C. Ear or body piercing using **shared** instruments or needles performed ***in preceding 12 months***

If present, note **specific** date(s): ______________________________ (MM/DD/YYYY)

D. West Nile Virus such as fever, headache, body aches, eye pain, lymphadenopathy, neck stiffness, skin rash on the trunk, stupor, disorientation, tremors, convulsions, and muscle weakness or paralysis

E. HIV-1/2 such as disseminated lymphadenopathy, blue or purple spots consistent with Kaposi's sarcoma, or unexplained oral thrush

F. Hepatitis B and C such as unexplained jaundice, hepatomegaly, or icterus

G. Vaccinia virus infection such as generalized vesicular rash (generalized vaccinia), large scab consistent with recent smallpox immunization, severely necrotic lesions consistent with vaccinia necrosum, eczema vaccinatum, or corneal scarring consistent with vaccinal keratitis

H. HTLV I/II such as unexplained paraparesis

I. Chagas such as fever, lymphadenopathy, myocarditis/cardiomyopathy, or hepatosplenomegaly

J. Creutzfeldt-Jakob disease (CJD) or variant CJD such as dementia

K. Sepsis or systemic infection such as unexplained generalized rash or fever

L. Syphilis such as palmar rash, fever or other constitutional symptoms

M. Zika such as fever, rash, headache, joint pain, conjunctivitis, or muscle pain

MARK ONE:

1. Are any of the above present upon exam? → **YES** ☐ *If YES, explain below; then go to Section 2.*
NO ☐ *If NO, go to Section 2.*

Comments:

*FDA Guidance for the Industry *Eligibility Determination for Donors of Human Cells, Tissue, and Cellular and Tissue-Based Products (HCT/Ps)*, August 2007

BE THE MATCH

Donor Name: ______________________

GRID: ______________________

SECTION 2 Genitourinary Examination Findings

1. **Does this person report being in either category below?**
   A. Man who has had sex with another man in the past 5 years
   B. Female partner in the past 12 months of a man who had sex with another man in the past 5 years

→ **MARK ONE:**
YES ☐ *If YES, perform GU exam and mark YES or NO below.*
NO ☐ *If NO, sign Section 3 only.*

➧ Genitourinary exam to include exam for ulcerative disease, herpes simplex, chancroid, or chondyloma in genital or anal areas.

2. **Did GU exam identify any risk or presence of infection?**

→ **YES** ☐ *If YES, explain findings below; then sign Section 3.*
NO ☐ *If NO, sign Section 3 only.*

Comments:

SECTION 3 Signature

Completed by ***EXAMINING MEDICAL PROFESSIONAL***

As a licensed medical practitioner, I performed a physical examination of this potential donor and recorded the outcome in Sections 1 and 2.

Printed Name/Title	**Signature**	**Date**

↓

THANK YOU.

The Examining Medical Professional actions are complete with Section 3 signature.

SECTION 4

Completed by ***DONOR CENTER MEDICAL DIRECTOR*** or designee

Based upon the preceding documented examination for physical evidence or risk for communicable disease, I have determined that this person:

MARK ONE:

A. **<u>Does not</u> exhibit physical evidence or risk for communicable diseases.** → **A.** ☐

B. **<u>Does</u> exhibit physical evidence or risk for communicable diseases.** **B.** ☐

If YES was selected in Sec 1 or for Q#2 in Sec 2, it is expected that B would be marked in Sec 4. If B is marked, explain findings.

Printed Name/Title	**Signature**	**Date** (DD/MMM/YYYY)

NATIONAL MARROW DONOR PROGRAM® BE THE MATCH®

Date: ____________

Physical Examination Request Cover Letter

To:	____________	**From:**	____________
Company:	____________	**Company:**	____________
Fax:	____________	**Fax:**	____________
Email:	____________	**Email:**	____________
Phone:	____________	**Phone:**	____________
# Pages:	____________		

GRID: ____________

Donor Name: ____________

Target Physical Examination Date/Time: ____________

Included in the Donor Physical Examination packet are the following:

Important information: To ensure the best experience for you and our donor, you are asked to watch this short video https://www.clinicalproviderconnect.org/Physical-Exam/ outlining the process involved in conducting a physical examination for Be The Match/NMDP donors.

- ☐ Acceptance Letter for Third Party Physical Exam Providers
- ☐ Physical Examination Checklist for Third Party Providers
- ☐ Physical Examination Report
- ☐ Addendum to Physical Examination
- ☐ Venous Assessment Worksheet
- ☐ Billing Instructions & Fee Schedule
- ☐ Completed Health History Screening
- ☐ Donor Lab Results (when tested elsewhere)

Additional information:

Thank you for participating in our life-saving program.

The National Marrow Donor Program® (NMDP) is the global leader in providing marrow and umbilical cord blood transplants to patients with leukemia, lymphoma and other diseases. The nonprofit organization matches patients with donors, educates health care professionals and conducts research so more lives can be saved.

The NMDP also operates Be The Match®, which provides support for patients and enlists others in the community to join the Be The Match Registry® (the world's largest listing of potential marrow donors and donated cord blood units), contribute financially, and volunteer.

NMDP/Be The Match supports every aspect of the transplant process.

We help patients and families.

We help doctors who treat patients.

We advance transplant science.

Frequently Asked Questions for Physical Exam Providers

Who is the National Marrow Donor Program® (NMDP)/Be The Match®?

The NMDP is the global leader in providing blood stem cells and umbilical cord blood transplants to patients with leukemia, lymphoma, and other diseases. Our nonprofit organization matches patients with donors, educates health care professionals, and conducts research so more lives can be saved. We provide support for patients, families and enlist others in the community to join the Be The Match Registry® (the world's largest listing of potential marrow donors and donated cord blood units), contribute financially, and volunteer. NMDP/Be The Match supports every aspect of the transplant process. We help doctors who treat patients. We guide donors through their donation journey. We advance transplant science. People's lives literally depend upon our performance.

Why do you call these individuals 'donors?' Did they donate money to your organization?

When a person joins the Be The Match Registry, they are considered a registry member. Once they are identified as the best match for a patient and are asked to donate their blood stem cells, they are called donors.

Why do donors need physical exams?

Once a patient finds a matching donor, NMDP/Be The Match requires every donor to go through a complete physical exam (PE). The evaluation performed at a physical exam ensures the donor is healthy enough to donate blood stem cells.

Why doesn't NMDP/Be The Match complete the physical exam?

NMDP partners with several providers to conduct physical exams across the United States. NMDP physicians use the information gathered at the exam to make the ultimate decision on whether a donor can proceed with donation.

Who is my main point of contact from NMDP/Be The Match?

The main point of contact will be noted on the Physical Examination Request Cover Letter.

Why is confidentiality important with NMDP/Be The Match donors?

NMDP donors **DO NOT** know the location where the patient receiving their cells lives. NMDP requires all of our partners to maintain our strict confidentiality policy. **Do not disclose where any NMDP kits are being sent.**

How can I learn more about the venous assessment?

NMDP has a training video that you can view here:

https://www.ClinicalProviderConnect.org/Physical-Exam/

Why do I ship kits to different locations?

NMDP/Be The Match has many regulatory requirements that mandate who tests samples from donors. Therefore, you may have multiple kits to draw and ship.

Why do I conduct another Health History if you've already provided one to me?

Donor safety is our highest priority. Therefore, to ensure accuracy, we are asking you to review and confirm the information the donor previously provided to us in a verbal interview.

NATIONAL MARROW DONOR PROGRAM® BE THE MATCH®

GRID: ______________________

Donor Name: ______________________________________

DOB: __________

Physical Examination Checklist for Third Party Providers

Please complete this checklist to confirm all aspects of the physical exam have been completed.

- **Required** column: Completed by NMDP/Be The Match.
- **Completed** column: Completed by your facility confirming the aspects of the physical exam performed by your facility.

Required	Completed	
		• This donor has agreed to donate blood stem cells to a matched patient in need of a life-saving transplant. • We ask you to conduct a physical assessment of the donor; Be The Match medical staff will determine if the donor can proceed to donation. • The physical examination must be performed by an MD, DO, PA, or NP. • Please submit results/paperwork as soon as possible or within three days of the exam.

Required	Completed	Item	
		ACCEPTANCE LETTER FOR THIRD PARTY PROVIDERS	
☐	☐	Must be reviewed, signed by a medical provider annually, and returned before completion of physical exam.	
☐	☐	There is a current Acceptance Letter for Third Party Providers on file for your medical facility.	
		TRAINING - NMDP PHYSICAL EXAMINATION REQUIREMENTS AND PAPERWORK	
■	☐	Performing/examining personnel must review training at: https://www.clinicalproviderconnect.org/Physical-Exam/	
		PHYSICAL EXAM AND PAPERWORK - TO BE COMPLETED/REVIEWED BY MEDICAL PROVIDER (NOT THE DONOR)	
■	☐	**Physical Examination Report:** History & Physical and Review of Systems (4 pages)	
■	☐	**Addendum to Physical Examination*:** Communicable disease risk assessment (2 pages)	
☐	☐	* Genitourinary (GU) Exam: Only needed based upon the donor's exam and risk factors	
☐	☐	**Venous Assessment Worksheet:** Performed with a blood pressure cuff or tourniquet (1 page)	
■	☐	**Review provided Donor Health History Screening Questionnaire.**	
		REQUIRED LABS - PROVIDER MUST REVIEW PRIOR TO SIGNING PAGE 4 OF THE PHYSICAL EXAM REPORT **INCLUDE TWO DONOR IDENTIFIERS ON EACH PAGE**	
	☐	☐ **Perform and review test results.** ☐ **Review tests results (performed elsewhere and provided to you).**	
☐	☐	Comprehensive Metabolic Profile: Electrolytes, BUN, Creatinine, Alkaline Phosphatase, Alanine Aminotransferase (ALT, SGPT), Glucose, Serum Total Protein plus albumin	80053
☐	☐	Complete Blood Count with Differential (includes Hemoglobin, Hematocrit, and Platelet Count)	85025
☐	☐	Lactate Dehydrogenase	83615
☐	☐	Urinalysis with Microscopy	81000/81001
		VARIABLE TESTS - INCLUDE TWO DONOR IDENTIFIERS	
	☐	☐ **Perform and review test results.** ☐ **Review tests results (performed elsewhere and provided to you).**	
☐	☐	**Serum** Beta-HCG pregnancy (quantitative/qualitative, females of childbearing potential only)	84702
☐	☐	PT (includes INR)	85610
☐	☐	PTT	85730
☐	☐	Magnesium	83735
☐	☐	Phosphorous	84100
☐	☐	Chest X-Ray (dual view: front + lateral) - NMDP required or at provider discretion	71020
☐	☐	EKG (includes 93010 professional evaluation + 93005 tracing) - NMDP required or at provider discretion	93000
☐	☐	Other (specify):	
		NMDP BLOOD SAMPLE DRAW KIT(S)	
	☐	☐ IDM (Blue) ☐ Research (Black) ☐ Pre-Collection (Green)	
	☐	These kit(s) are for additional testing to be performed at NMDP Be The Match labs.	
	☐	Kit(s) will be shipped to you in advance, including tubes, labels, shipping materials, and FedEx airbills.	
	☐	Draw tubes in the kit(s) and ship via FedEx same day as drawn.	
		REVIEW BILLING INSTRUCTIONS & FEE SCHEDULE	
■	☐	Outlines how much NMDP pays for the physical exam, labs, etc.	
■	☐	Donors and their personal insurance carriers are not to be invoiced for NMDP-related testing.	

Questions? Contact at

Please return the Physical Exam paperwork + lab results to (fax) or email

NATIONAL MARROW DONOR PROGRAM® BE THE MATCH®

GRID: ______________________

Physical Examination Report

Date of Evaluation: ______________

Name (First Middle Last):			
Purpose of Exam: Evaluate volunteer's medical suitability to serve as unrelated donor of marrow and/or PBSC.	DOB (M/D/Y):	Age:	Male ○ Female ○

Instructions:

- Prior to examination, review completed NMDP Donor Health History Screening Questionnaire provided by donor center staff.
- Answer all Yes/No questions throughout this document. Explain any Yes response in space provided.
- Complete F00806, *Addendum to Physical Examination: Assessment for Physical Evidence or Risk of Communicable Diseases.*

SECTION 1: **Vital Signs**

BP*	P	T ☐F ☐C	R	H ☐ft ☐cm	W ☐lb ☐kg	Pain (1-10) ______ *If pain present, explain:*
					BMI	

**Repeat BP if initial reading is >160 systolic or >100 diastolic:* ______________

SECTION 2: **Past Medical History**

Part A

1. Any serious illness/injury requiring hospitalization, medications, or treatment by a medical clinician in the past 6 months?		**Yes** ☐ **No** ☐
2. Any past surgeries?		**Yes** ☐ **No** ☐
3. Any serious adverse reactions to anesthesia?	NA ☐	**Yes** ☐ **No** ☐
4. Permanent deferral from blood donation?	NA ☐	**Yes** ☐ **No** ☐
5. Pregnancy within the past 6 months or uninterruptable breastfeeding?	NA ☐	**Yes** ☐ **No** ☐

Part B

If Yes, mark ALL applicable conditions:

1. **Hematological conditions?** (Bleeding and/or Clotting conditions) **Yes** ☐ **No** ☐

☐ Deep vein thrombosis ☐ Thromboembolism ☐ Other; specify: ______________________

☐ Sickle Cell Trait ☐ Hemorrhage requiring medical attention; *mark ALL appropriate:*

☐ Sickle Cell Disease ☐ Gastrointestinal ulcer ☐ Genitourinary / Hemorrhagic cystitis ☐ Other; specify: __________

☐ Central Nervous System ☐ Significant surgical / Postpartum bleeding or trauma

Comments: ____

2. **Autoimmune disorders**, including rheumatic diseases? **Yes** ☐ **No** ☐

☐ Multiple sclerosis ☐ Rheumatoid arthritis ☐ Scleroderma ☐ Lupus ☐ Iritis / Episcleritis

☐ Autoimmune thyroid disease (e.g. Graves' or Hashimoto's) ☐ Hypopigmentation of the skin or mouth; specify: __________

☐ Psoriasis ☐ Other; specify: ______________ Comments: ______________________

3. **Cardiovascular conditions?** **Yes** ☐ **No** ☐

☐ Dysrhythmias; specify (i.e. atrial, ventricular): ______________________________

☐ Congestive heart failure ☐ Angina pectoris ☐ Coronary heart disease (no prior MI) ☐ Myocardial infarction

☐ Hypertension ☐ Dyspnea ☐ Other; specify: ______________________

Comments: ____

4. **Central Nervous System conditions?** **Yes** ☐ **No** ☐

☐ Brain surgery / injury / bleed* ☐ Meningitis / Encephalitis ☐ Seizure disorder ☐ CVA / TIAs ☐ Syncope

**include total concussions/injuries/bleed/surgeries, dates, specific diagnoses, symptoms, and duration of symptoms*

☐ Other; specify: ______________ Comments: ______________________________

Donor Name: ____________

GRID: ____________

5. **Psychiatric conditions?** Yes ☐ No ☐
☐ Bipolar disorder ☐ Anxiety ☐ Post-traumatic stress disorder ☐ Current treatment with Lithium
☐ Depression ☐ Panic attacks; list triggers: ____________
☐ Other; specify: ____________ Comments: ____________

6. **Endocrine condition?** Yes ☐ No ☐
☐ Diabetes mellitus ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Osteoporosis
☐ Other; specify: ____________ Comments: ____________

7. **Gastrointestinal / Liver conditions?** Yes ☐ No ☐
☐ Crohn's disease ☐ Ulcerative colitis ☐ Gastroesophageal reflux disease (GERD)
☐ Jaundice / liver disease ☐ Chronic viral hepatitis ☐ Drug-induced liver toxicity
☐ Cirrhosis ☐ Positive test or exposure to hepatitis ☐ Irritable bowel syndrome
☐ Peptic ulcer ☐ Other; specify: ____________
Comments: ____________

8. **Genitourinary conditions?** Yes ☐ No ☐
☐ Renal insufficiency ☐ Kidney stones ☐ Hematuria ☐ Other; specify: ____________
Comments: ____________

9. **Pulmonary conditions?** Yes ☐ No ☐
☐ COPD ☐ Asthma / Reactive airway disease ☐ Chronic cough ☐ History of pneumothorax
☐ Any acute respiratory disease or history of respiratory disease; specify: ____________
☐ Other; specify: ____________ Comments: ____________

10. **Orthopedic conditions?** Yes ☐ No ☐
☐ Chronic back/neck/hip pain; specify site and management: ____________
☐ Herniated disc ☐ Chronic lower extremity pain; specify management: ____________
☐ History of hip, spine or pelvic fracture ☐ Scoliosis ☐ Paresthesia / dysesthesias / neuropathic pain / sciatica in lower extremities
☐ Other; specify: ____________ Comments: ____________

11. **Other significant coexisting diseases?** Yes ☐ No ☐

SECTION 3: **Social History Review**

If Yes, indicate length and frequency of use.

Tobacco	Yes ☐ No ☐
Alcohol	Yes ☐ No ☐
Recreational Drugs	Yes ☐ No ☐

SECTION 4: **Family Medical History Review**

1. Any pertinent family history, including **a)** any first degree relative with history of leukemia or lymphoma; **b)** two or more blood relatives with any type of cancer; or **c)** any family members who experience difficulties with anesthesia? Yes ☐ No ☐
If Yes, explain:

SECTION 5: **Medications**

1. Taking medications, including experimental therapy or investigational agents? Yes ☐ No ☐
If Yes, list name(s) and purpose:

2. Any vaccinations in past 12 months? Yes ☐ No ☐
If Yes, list including dates:

Donor Name: ____________________

Physical Examination Report

GRID: ____________________

SECTION 6: **Allergies**

1. Any known allergies*, including any allergies to filgrastim or E. coli-derived recombinant protein products? *If Yes, explain:*	Yes ☐ No ☐
**include all drug, food, and environmental allergies*	

SECTION 7: **Review of Systems**

ALL SYSTEMS BELOW ARE NORMAL? Yes ☐ No ☐

System	*If above is marked No, mark applicable Abnormal system(s) below; describe Abnormal findings.*
1. General	ABNORMAL ☐
2. Eyes/HENT	ABNORMAL ☐
3. Cardio	ABNORMAL ☐
4. Resp/Chest	ABNORMAL ☐
5. GI	ABNORMAL ☐
6. GU	ABNORMAL ☐
7. Lymph	ABNORMAL ☐
8. Mus/Skel (Neck/Back/Hip)	ABNORMAL ☐
9. Skin	ABNORMAL ☐
10. Neuro	ABNORMAL ☐
11. Psych	ABNORMAL ☐

SECTION 8: **Physical Examination**

System	*Mark findings as appropriate. Describe any Abnormal findings.*		
1. General	Well-nourished; well-developed; no apparent distress	NORMAL ☐	ABNORMAL ☐
2. Eyes	Extraocular movements intact; pupils equal and reactive to light; no scleral icterus	NORMAL ☐	ABNORMAL ☐
3. Head/Ears/ Nose/Throat	Normocephalic, TMs intact and noninflamed, no nasal congestion, NL oropharynx, mucous membranes clear	NORMAL ☐	ABNORMAL ☐
4. Cardio	NL S1S2; no gallop, murmur, edema or jugular venous distension	NORMAL ☐	ABNORMAL ☐
5. Resp/Chest	Clear to auscultation; no cough or wheeze	NORMAL ☐	ABNORMAL ☐
6. GI	Soft and non-tender; NL bowel sounds; no hepatosplenomegaly or mass	NORMAL ☐	ABNORMAL ☐
7. Lymph	No cervical, supraclavicular, axillary, or inguinal adenopathy	NORMAL ☐	ABNORMAL ☐
8. Mus/Skel	NL strength and gait; no cyanosis; NL range of motion; no tenderness of neck, back, hips and shoulders	NORMAL ☐	ABNORMAL ☐
9. Skin	Clear; no rash, petechiae, ecchymosis, or jaundice	NORMAL ☐	ABNORMAL ☐
10. Neuro	NL cranial nerves, deep tendon reflex, and light touch	NORMAL ☐	ABNORMAL ☐
11. Psych	NL mood & affect / alert & orientated person, place and situation	NORMAL ☐	ABNORMAL ☐
12. Extremities	Evaluation of venous access for apheresis: Good ☐ Fair ☐	Poor ☐	Not Examined ☐

SECTION 9: **Test Findings**

- Additional testing may be required by the transplant center and/or collection facility; instructions will be provided by the donor center staff.
- The following test results are specific **exclusion criteria** for PBSC donation:
  - Thrombocytopenia <150 x 10^9L at baseline evaluation (Platelet count may be repeated to confirm.)
  - Sickle cell trait
- Required laboratory tests for all NMDP donors include:
  1. Hematology: Hemoglobin, Hematocrit, CBC with white blood cell differential, platelet count
  2. Chemistries: Electrolytes (Na, K, Chloride, bicarbonate [HCO_3 or CO_2]), Glucose, ALT(SGPT), LDH, Alkaline Phosphatase, BUN, Creatinine, Serum Total Protein plus albumin or serum protein electrophoresis
  3. Urinalysis with reflex to microscopy, if available (by lab analysis or Clinitek)
  4. Serum Beta HCG, if female of childbearing potential

Required Tests: *Mark result:*

Test	NL	ABNL	*Describe any Abnormal results.*
Laboratory	☐	☐	
Urinalysis	☐	☐	
Pregnancy (Serum Beta HCG)	**Neg** ☐	**Pos** ☐	**NA** ☐ (Mark if male or female of non-childbearing potential)

Elective Tests:

- CXR and EKG are not required by the NMDP. However, these tests may be performed at the discretion of the examining clinician or the collection facility or donor center clinicians based on medical judgement.

If performed, mark result:

Test	Performed?	NL	ABN	*Describe any Abnormal results.*
EKG	Yes ☐ No ☐	☐	☐	
CXR	Yes ☐ No ☐	☐	☐	
Other, list:		☐	☐	

SECTION 10: **Evaluation Impression** *Mark applicable box:*

After performing a history and physical examination of this volunteer donor and reviewing their test results,

1. NO MEDICAL PROBLEMS IDENTIFIED **1.** ☐

I find no significant medical problems that would prevent this person from serving as a volunteer stem cell donor or any issue making the collection of marrow under general anesthesia unusually hazardous. Medical conditions may be present but are stable and well-controlled with current therapy.

2. MEDICAL PROBLEMS IDENTIFIED THAT MAY OR MAY NOT REPRESENT DONOR OR RECIPIENT SAFETY RISKS **2.** ☐

I have identified the following medical problem(s) which may or may not impact the safety of the donor and/or recipient and should be evaluated by the appropriate medical staff prior to collection of stem cells. Explain in comment section below.

3. MEDICAL PROBLEMS WERE IDENTIFIED THAT REPRESENT DONOR OR RECIPIENT SAFETY RISKS **3.** ☐

I have identified the following medical problem(s) which impact(s) the safety of the donor and/or recipient and I do not recommend this person serve as a stem cell donor. Explain in comments section below.

Comments:

Examining Medical Clinician:

Printed Name **Signature** **Title** **Date**

Auto-Fillable Physical Examination Packet

The Auto-Fillable Physical Examination Packet is a tool available for use by donor center (DC) staff to prepare for the donor's physical examination. DC staff can enter information on this page to populate on additional pages within the packet.

CONTENTS:

- F01103, *Physical Examination Request Cover Letter*
- F00822, *Acceptance Letter for Third Party Physical Exam Providers*
- F01097, *Physical Examination Checklist for Third Party Providers*
- F00476, *Physical Examination Report*
- F00806, *Addendum to Physical Examination*
- F00820, *Venous Assessment Worksheet*
- *Frequently Asked Questions*
- *Fee Schedule & Billing Instructions*

DONOR INFORMATION:			
Donor Full Name:			
GRID:			
Donor Age:		Donor Sex:	Male ○ Female ○
First two digits of provider's zip code:		Donor Date of Birth: (mm/dd/yyyy)	
DONOR CENTER COORDINATOR INFORMATION:			
Donor Center Coordinator Name:			
DC Coordinator Email:			
DC Coordinator Phone:		DC Coordinator Fax:	

NOTES:

- Download the packet prior to each use. **DO NOT** reuse a previously downloaded packet.
- Open the packet with **Adobe Acrobat Pro** or **Adobe Acrobat Reader**. **DO NOT** use a web browser to open and complete the packet.
- F01103, *Physical Examination Request Cover Letter*: Prior to printing to Microsoft PDF, manually complete fields not pre-populated by entries on the first page.
- F00822, *Acceptance Letter for Third Party Physical Exam Providers*: Manually complete fax and email information, if applicable.
- F01097, *Physical Examination Checklist for Third Party Providers*: Manually customize requirements for each donor. DC contact information will pre-populate from first page.
- *Fee Schedule & Billing Instructions*: Select the first two digits of the provider's zip code.
- Delete this page before sending to the provider.
- Additional documents (e.g., HHSQ, donor labs) may need to be included separately.