CENTRUM ORGANIZACYJNO-KOORDYNACYJNE ds. TRANSPLANTACJI
Centralny Rejestr Potencjalnych Niespokrewnionych Dawców Szpiku
i Krwi Pępowinowej POLTRANSPLANT
02-001 Warszawa, Al. Jerozolimskie 87

Tel/fax (+48-22) 627 07 48 e-mail: rejestr@szpik.info

Warszawa, 22 czerwca 2017 r.

PRESCRIPTION FOR MARROW COLLECTION

(To be completed by the transplant center)

Patient name:	Patient ID number: (assigned by patient's registry)
Transplant Center:	Patient ID number: (assigned by donor's registry)
Donor registry: CRNDSiKP(PL5)	Donor ID number**: PL5-ID- ……**

PRE-COLLECTION PERIPHERAL BLOOD SAMPLES *(maximum 100 mls):*

	mls EDTA		mls ACD	Other, please specify:
	mls Heparin		mls no anticoagulant	

Samples to be shipped to: Name: Address: **NOTE:** This blood will be shipped at the time of the donor physical exam unless otherwise requested.	Invoice(s) to be sent to: Name: Address: NOTE: All invoices associated with the blood sample procurement / shipment, donor work-up and stem cell collection should be sent to this address for payment (list only the requesting hub's address).
Phone no:	Phone no:
Fax no:	Fax no:
Email:	Email:

MARROW COLLECTION

REQUIRED NUCLEATED CELLS PER KG (UNCORRECTED)	X10^8/kg
x recipient weight (kg)	kg
= total nucleated cells for recipient (uncorrected)	X10^8
+ nucleated cells for quality assurance	X10^8
= Total nucleated cells	X10^8
Required anticoagulant: Heparin u/mls ACD vol ACD/vol BM	

Required media for marrow transportation:
Packing instructions for transport: (i.e. temperature, special requirements, etc)

PERIPHERAL BLOOD SAMPLES TO BE COLLECTED AT TIME OF HARVEST frnax 100 *mls):*

	mls EDTA		mls ACD	Marrow Tube:
	mls Heparin		mls no anticoagulant	
Additional comments:				

Transplant physician: (day/month/year)	Signature:	Date: