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

Warszawa, 22 czerwca 2017 r.

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

PRESCRIPTION FOR T-CELLS

(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: CRNPDSiKP(PL5)	Donor ID number: **PL5-ID-** _____
Transplant centre address:	Contact name:
	Phone:
	Fax:
	e-mail:
Diagnosis and current disease stage:	
Description of patient's post-transplantation condition and reason for request:	
Proposed Collection Date:	

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:

T-CELL COLLECTION:

Required CD3 pos. cells per kg	x 10^6/kg
x recipient weight (kg)	kg
= total number of CD3 pos. cells	x10^6

Specify T-cell transport conditions:
Room temperature: Cooled:

Additional comments:

DAY OF COLLECTION PERIPHERAL BLOOD SAMPLES

	mls. EDTA		mls. ACD	Other:
	mls. Heparin		mls. no anticoagulant	

Transplant physician:	Signature:	Date: