ARGENTINE STEM CELL DONOR REGISTRY

Ramon Carrillo 489 3er Piso
C1275AHI- Buenos Aires - Argentina
Tel.: 54 11 5533-1311
Fax: 54 11 5533-1310
E-mail: registro@incucai.gov.ar

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:	Donor ID number:

PRE-COLLECTION PERIPHERAL BLOOD SAMPLE *(maximum 50mls):*

	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 invoice associates with the blood sample procurement / shipment, donor work-up and stem cell collection should be sent to this address for payment (list only the requested hub's address)
Phone n°.:	Phone n°:
Fax n°:	Fax n°:
E-mail:	E-mail:

MARROW COLLECTION

Required nucleated cells per kg (uncorrected)	X 10^8/kg
x recipient weight (kg)	Kg
= total nucleated cells for recipient (uncorrected)	X 10^8
+ nucleated cells for quality assurance	X 10^8
= Total nucleates cells	X 10^8
IRB / Ethics Board (or equivalent) Approval	(Yes/No or date)

Required anticoagulant: Heparin ________ u/mls ACD _________ vol ACD/vol BM Other (please specify):
Required media for marrow transportation: ROOM TEMPERATURE
Packing instructions for transport: (i.e. temperature, special requirements, etc)

PERIPHERAL BLOOD SAMPLES TO BE COLLECTED AT TIME OF HARVEST *(max. 100 mls)*

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

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