ARGENTINE STEM CELL DONOR REGISTRY

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PRESCRIPTION FOR STIMULATED PERIPHERAL BLOOD STEM CELL 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 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 requester.	**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:

STIMULATED PBSC COLLECTION

Required CD34+ cells per kg	X 10^6/kg
x recipient weight (kg)	Kg
= total number of CD34+ cells	X 10^6
+ CD34+ cells for quality tests	X 10^6
= Total number of CD34+ cells	X 10^6

Preferred method of overnight storage (if needed) of apheresis product(s):
Packing instructions for transport (i.e. temperature): 4º C
Additional comments:

PERIPHERAL BLOOD SAMPLES TO BE COLLECTED AT FIRST APHERESIS

	mls EDTA		mls ACD	Other:
	mls Heparin		mls no anticoagulant	
Additional comments:				

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