**To be completed by the Transplant Center**

| Patient Name: | Transplant Center |
|---|---|
| Patient ID: | Donor Registry |
| Donor ID: | Donor Grid: |

**Pre-Collection Peripheral Blood Samples** (maximum 30ml)

| ml | EDTA | ml | ACD | Other, please specify |
|---|---|---|---|---|
| ml | Heparin | ml | 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

| Phone nº. | Phone nº. |
|---|---|
| Fax nº. | Fax nº. |
| E-mail | E-mail |

**Stimulated PBSC Collection** (two alternative ways of requesting PBSC*)

| Required CD34+ cells per Kg | X $10^6$/Kg |
|---|---|
| X recipient body weight (Kg) | Kg |
| = total number of CD34+ cells | X $10^6$ |
| +CD34 + cells for quantity tests | X $10^6$ |
| = Total number of CD34+ cells | X $10^6$ |

| Nº. of aphaeresis after g-csf mobil. |
|---|
| ☐ One aphaeresis of ≥ 12 liters |
| To be considered for pat. < 70Kg |
| ☐ Two aphaeresis of ≥ 12 liters each |
| To be considered for pat. ≥ 70Kg |

* Please use only one category of request.

**Additional Information**

| In vitro manipulation | ☐ T cell depl | ☐ CD34+ selection | ☐ Wash product | ☐ Other, specify | ☐ Cryopres. |
|---|---|---|---|---|---|
| In this transpl. a part of an established or an experimental protocol? | | | ☐ Established | | ☐ Experimental* |

*If an experimental protocol, please enclose a brief documentation

| Preferred method of overnight storage (if needed) of aphaeresis product(s): |
|---|
| Additional comments: |

**Peripheral Blood Samples to be collected at the Time of Harvest**

| ml | EDTA | ml | ACD | Other (i.e. plasma) |
|---|---|---|---|---|
| ml | Heparin | ml | No anticoagulant | |
| Additional comments: | | | | |

| Person completing the form | Signature | Date |
|---|---|---|
| | | |