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

Marrow Collection

Required nucleated cells per Kg (uncorrected)		X 10^8/Kg
X recipient body weight (Kg)		Kg
= total nucleated cells for recipient (uncorrected)		X 10^8
+ nucleated cells for quality assurance		X 10^8
= Total nucleated cells		X 10^8
Estimated minimum volume based on request total nucleated cell count (not to exceed 1500ml)		ml

Required anticoagulant: Heparin _____IU/ml ACD 1: _____ vol ACD: vol BM Other, please specify:
Required media for marrow transportation (i. e. antibiotics) (Please advise if courier will be delivering your own prepared medium the day preceding harvest)

Peripheral Blood Samples to be collected at the Time of Harvest

ml	EDTA	ml	ACD	Marrow Tube
ml	Heparin	ml	No anticoagulant	
Additional comments:				

Person completing the form	Signature	Date