(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

Peripheral Blood Lymphocyte Collection (two alternative ways of requesting PBLY)

Required CD3- cells per Kg	**X 10^6/Kg**
X recipient body weight (Kg)	**Kg**
= total number of CD3- pos. cells	**X 10^6**
+CD3- pos. cells for quantity tests	**X 10^6**
= Total number of CD3- cells	**X 10^6**

Product
☐ Aphaeresis
To be considered for pat. < 70Kg
☐ Whole blood anticoagulated Maximum 200ml

* Please use only one category of request.

Additional Information

In vitro manipulation	☐ Cryopres.	☐ Wash product	☐ Other, specify

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) / Whole blood:

Additional comments:

Peripheral Blood Samples to be Collected at the Time of Harvest

ml	EDTA	ml	ACD	Other
ml	Heparin	ml	No anticoagulant	

Additional comments:

Person completing the form	Signature	Date