VERIFICATION FORM FOR BM PRESCRIPTION

PATIENT		
Patient Name:	Patient ID:	Weight (Kg):
Transplant Center (TC):		

DONOR	
Donor GRID:	Weight (Kg):

SECTION A : TO BE COMPLETED BY THE DONOR CENTER (DC)	
Total number of MNC requested by TC on the BM Prescription :	$x10^8$
Donor Center Signature:	**Date:**

SECTION B: TO BE COMPLETED BY THE COLLECTION CENTER (CC)

Collection Center Name:	BM Collection Date(s) of Collection (DD/MM/YY) ____/____/_____ and ____/____/_____		Peripheral Blood to be collected at the time of BM collection
Contact Person:	Total number of MNC requested	$x10^8$	☐ _____ mls Heparin ☐ _____ mls ACD ☐ _____ mls EDTA ☐ _____ mls no anticoagulant ☐ _____ mls Product sample
Telephone: FAX: Email:	Anticoagulants and medium: Heparin: ____ ACD: ____ Other _____ Donor Plasma requested: Yes: ____ No: ____ Amount: _____		
Address:			

Estimated number of Collections: ☐ one ☐ two

Based on the experience at this collection center, we feel that the requested number of MNC is:

☐ FEASIBLE

NOTE: This is not a guaranty that the requested number of cells will be supplied. The number of cells collected may be larger or smaller.

☐ NOT FEASIBLE

Comments:_____

Collection Center Signature:	**Date:**

SECTION C: TRANSPLANT CENTER ACCEPTANCE OF TERMS PROVIDED BY DC AND CC

DISCLAIMER: The cell products collected from this donor are intended solely for the purpose of immediate therapeutic treatment for the above mentioned patient. Excess cells may be stored for future infusion for this patient. No other uses of these cells are permissible. Cells not used for therapeutic treatment of the above mentioned patient must be disposed of properly. The donor center must be provided detailed information concerning the use and/or disposal of all portions of this cell product. By accepting these cells, the transplant physician also accepts these terms and conditions. Requests for deviations from these terms must be submitted in writing to the donor center approval.

Transplant Center Signature:	**Date:**