PRESCRIPTION FOR STIMULATED PERIPHERAL BLOOD STEM CELL COLLECTION

(To be completed by the transplant center)

Patient Name:	Transplant Center
Patient ID:	Donor Registry
Donor ID:	

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

GOVERNO DE PORTUGAL
MINISTÉRIO DA SAÚDE

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