Gift of Life Marrow Registry
800 Yamato Road, Suite 101
Boca Raton, Florida 33431 USA

Phone: +1.561.982.2900
Donor Services Fax: +1.561.982.2902
Email: donors@giftoflife.org
giftoflife.org

# PRESCRIPTION FOR HPC, MARROW COLLECTION

**Instructions for Transplant Center:** Complete this Prescription and DS-WU-F602-6: Formal Stem Cell Donor Work-up Request (First Transplant). Send them together with the donor's HLA typing obtained at CT to donors@giftoflife.org or fax to +1.561.982.2902.

| | |
|---|---|
| **Patient Name:** | **Patient ID Number:** |
| **Transplant Center:** | **Donor ID Number:** |

## PRE-COLLECTION PERIPHERAL BLOOD SAMPLES

**Note:** Maximum of 50 mL blood will be shipped at the time of the donor physical exam unless otherwise requested.

| | | | | |
|---|---|---|---|---|
| | mL EDTA | | mL ACD | **Shipping Information:** |
| | mL Heparin | | mL No Anticoagulant | Attn / Name: ..... |
| Other: | | | | Center: ..... |
| | | | | Address: ..... |
| | | | | ..... |
| | | | | City, State, Zip: ..... |
| | | | | Country: ..... |
| | | | | Phone: ..... |
| | | | | Fax: ..... |
| | | | | E-mail: ..... |

## MARROW COLLECTION

| | | |
|---|---|---|
| REQUIRED NUCLEATED CELLS PER KG (UNCORRECTED) | | x $10^8$ / kg |
| x Recipient weight (kg) | | kg |
| = Total nucleated cells for recipient (uncorrected) | | x $10^8$ / kg |
| + Nucleated cells for quality assurance | | x $10^8$ / kg |
| = Total nucleated cells | | x $10^8$ / kg |

| | | | |
|---|---|---|---|
| Required anticoagulant | Heparin<br>u/mLS | ACD<br>Vol ACD/Vol BM | Other, specify: |

| | |
|---|---|
| Required media for marrow transportation | Packing instructions and temperature for transport |

## PERIPHERAL BLOOD SAMPLES TO BE COLLECTED AT TIME OF HARVEST (Maximum 50 mL)

| | | | | |
|---|---|---|---|---|
| | mL EDTA | | mL ACD | Marrow Tube |
| | mL Heparin | | mL No Anticoagulant | |
| Additional Comments ..... | | | | |
| ..... | | | | |
| ..... | | | | |

| | | |
|---|---|---|
| Transplant Physician Name and Title | Signature | Date |