Gift of Life
BONE MARROW FOUNDATION
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headquarters
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Boca Raton, Florida 33431 USA

telephone
561.982.2900

coordinating center fax
561.982.2901

donor services fax
561.982.2902

Prescription for MNC, Apheresis Collection

Transplant Center: Please complete form and fax to +1-561-982-2902 with Formal Workup Request.

Recipient Name:	Recipient ID Number:
Transplant Center Name:	Donor ID Number:

Pre-Collection Peripheral Blood Samples *Note: A maximum of 50 mL is shipped at the time of the donor physical exam unless otherwise requested.*		
EDTA _______ mL	Heparin _______ mL	Other, please specify:
ACD _______ mL	No anticoagulant _______ mL	

Address for shipment of samples: ____ ____ ____	Telephone Number: Fax Number: Email Address:

Cell Dose Calculation

Note: A maximum of 24 liters of donor blood will be processed in a single apheresis procedure to accommodate request.

Desired CD3+ cells / kg: ________ ($x10^7$) x Recipient weight ________ (kg) = ________ **($x10^7$)** **Total CD3+ cells**

Total CD3+ cells: _________ ($x10^7$) x 2 = _________ **($x10^7$) Total mononuclear cells (TMC)**

Total mononuclear cells (TMC) ÷ 100 $x10^7$ = _________ **Liters processed**

Storage and Transport Instructions	
Overnight Storage Temperature *(if needed)*:	Other additives and amounts:
Transport Temperature:	Packing instructions: (*Note: Facility supplying the courier is responsible for supplying the transport container.)*

IRB / Ethics Board (or equivalent) Approval: ☐ Yes ☐ No Date:

Blood Samples Required At Time of Collection		
	Peripheral Blood	**MNC(A) Product**
EDTA	_______ mL	_______ mL
Heparin	_______ mL	_______ mL
ACD	_______ mL	_______ mL
No anticoagulant	_______ mL	_______ mL

Additional Comments:

Transplant Physician Name:	**Signature:**	**Date:**