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 STIMULATED PERIPHERAL BLOOD STEM CELL 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
	mL Heparin		mL No anticoagulant
Other:			

Shipping Information:
Attn / Name: .....
Center: .....
Address: .....
.....
City, State, Zip: .....
Country: .....
Phone: .....
Fax: .....
E-mail: .....

STIMULATED PBSC COLLECTION

REQUIRED CD34 POS. CELLS PER KG		x 10^6 / kg
(x) Recipient weight (kg)		kg
(=) Total number of $CD34^+$ cells		x 10^6
(+) $CD34^+$ cells for quality testing		x 10^6
(=) Total number of $CD34^+$ cells		x 10^6

Add donor plasma: ☐ Yes ☐ No Amount:	Other additives and amounts: ☐ N/A
Please list requested anticoagulant to be used:	
Required media for PBSC transportation:	Packing instructions and temperature for transport:

SAMPLES TO BE COLLECTED AT TIME OF APHERESIS

Collect samples on ☐ Day 1 Only ☐ Days 1 and 2 ☐ None

DONOR PERIPHERAL BLOOD (Max. 50 mL)				PBSC PRODUCT			
	mL EDTA		mL ACD		mL EDTA		mL ACD
	mL Heparin		mL No anticoagulant		mL Heparin		mL No anticoagulant

Transplant Physician Name and Title:	Signature:	Date: