Blood Systems

Submitting Facility: ______________________

Contact Person:

Phone Number:

Bone Marrow & Progenitor Cell Processing Prescription

Collection Date(s):	Collection Date(s):
Recipient Name: Diagnosis:	Donor Name:
Recipient ID No.: Recipient DOB:	Donor ID No.: Donor DOB:
Recipient Registry No.:	Donor Registry No.:
Recipient SSN: Recipient ABO/Rh:	Donor ABO/Rh:
Recipient Weight: kg	
☐ Known Heparin Allergy or HIT	☐ Known Heparin Allergy or HIT

IMPORTANT: Please attach Viral Marker Testing <30 days from anticipated collection date and for all Allogeneic Donors the Statement of Donor Eligibility or associated Donor Questionaires. Request aliquots in desired order of cryopreservation. Do not hesitate to call the laboratory if you are unable to provide instructions for all collected cells using this script.

☐ PBSC ☐ Donor Leukocytes ☐ Stimulated
☐ Bone Marrow ☐ Cord Blood ☐ Unstimulated

☐ Allogeneic

Fresh Dose (Choose one)

☐ No processing requested (count and infuse only, no frozen product to be made)

☐ _______ x 10^6 **CD34/kg** ☐ ______ x 10^7 **CD3/kg** ☐ ______ x 10^8 **TNC/kg**

Cryopreserved Dose (Choose at least one)

☐ in equal **CD34** aliquots ☐ in **CD3** aliquots per DLI protocol

☐ per ______________________ protocol

☐ Call ( ) - ______________ with flow counts for further instructions

☐ Custom cryopreserve as follows

☐ Autologous

Cryopreserved Dose (Choose one)

☐ Cryopreserve in fewest # of aliquots for a total of

_____________ transplants (e.g. doses) and minimum of

_____________ x 10^6 **CD34/kg** per transplant

☐ per ______________________ protocol

☐ Call ( ) - ________ with flow counts for further instructions.

☐ Custom cryopreserve as follows

IMPORTANT: Will be cryopreserved in equal aliquots as needed unless noted. Each line should be considered a separate dose. Relative priority will be **CD34**, then **CD3** and top to bottom, unless otherwise noted (1=highest).

CD34	________	x 10^6/kg	________	(priority)	**CD3**	________	x 10^7/kg	________	(priority)
	________	x 10^6/kg	________	(priority)	(DLI)	________	x 10^7/kg	________	(priority)
	________	x 10^6/kg	________	(priority)		________	x 10^7/kg	________	(priority)
	________	x 10^6/kg	________	(priority)		________	x 10^7/kg	________	(priority)
	________	x 10^6/kg	________	(priority)		________	x 10^7/kg	________	(priority)

Additional processing based on program's established protocols

☐ Send out (see instructions or protocol referenced, above)
☐ Plasma reduction (for minor incompatibility)
☐ Red cell depletion (for major incompatibility)
☐ Volume Reduction (for HPC, Marrow compatible product)

☐ Other or Special Instructions: ______________________

Physician's Signature: ______________________

Physician's Name (Print): ______________________

Number to call (day or night) for questions about prescription: ______________________

HPP 163 (Rev. 9)
HPC100

Blood Systems Laboratories
Cellular Therapy Laboratory
2424 W. Erie Dr./Tempe, AZ 85282
Phone 602-343-7103 Fax 602-343-7157

CTL Requisition Form

Date Of Request ______________ Draw Date ______________ UBS Center ______________

Report To ☐ Physician ☐ Laboratory ☐ UBS Center ☐ All Contact Person ______________

Referring Physician ______________

Facility Name ______________

Address ______________

____

Phone ______________ Fax # ______________

Laboratory ______________

Address ______________

____

Phone ______________ Fax # ______________

Bill To ☐ Physician ☐ Laboratory ☐ UBS Center ☐ Other

(If "Other" above, fill out "Bill To" information below.)

Bill To (If not physician, laboratory or center)

Name ______________

Address ______________

____

Phone # ______________ Fax # ______________

Samples Collected EDTA Qty _____ Other (______________) Qty _____

Item # VD	Quantity	Test Description	Item # VD	Quantity	Test Description
L01031	______	☐ CFU – Colony Forming Assay	L02051	______	☐ CD34/Viability
L01046	______	☐ Complete Blood Count			WBC ______ Vol.______ Pt. Wt. ______
L03042	______	☐ Manual Differential			
L01035	______	☐ Sterility	L01030	______	☐ CD3
L05045	______	☐ Trypan Blue Viability			

CTL Case #:

Patient Information (Recipient)

Last Name ______________ First Name ______________

Med. Record or SS # ______________ NMDP recipient ID ______________

Birthdate ______________ Sex: ☐ F ☐ M

Donor Information

Last Name ______________ First Name ______________

Med. Record or SS # ______________ NMDP Donor ID ______________

Birthdate ______________ Sex: ☐ F ☐ M Relationship ______________

FOR LABORATORY USE ONLY

Report sent: (F = Fax, V = Verbal, W = Written, E = Email)

☐ F ☐ V ☐ W ☐ E To ______________ Date ______________ Time ______________ Tech ______________
☐ F ☐ V ☐ W ☐ E To ______________ Date ______________ Time ______________ Tech ______________
☐ F ☐ V ☐ W ☐ E To ______________ Date ______________ Time ______________ Tech ______________

Comments

HPP 203 (Rev. 4)
HPC400