vitalant

Submitting Facility: _____

Contact Person:

Phone Number:

Bone Marrow & Progenitor Cell Processing Prescription

Collection Date(s):	Collection Date(s):
Recipient Name:	Donor Name:
Diagnosis:	Donor ID No.:
Recipient ID No.: Recipient DOB:	Donor DOB:
Recipient Registry No.:	Donor Registry No.:
Recipient SSN: Recipient ABO/Rh:	Donor ABO/Rh:
Recipient Weight: kg ☐ Ideal ☐ Adjusted ☐ NA	
☐ 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**

☐ None. Product to be cryopreserved (see below).

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 and minimum of

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

for total goal of _____ x 10^6 **CD34/kg**

☐ 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: _____

Vitalant
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 _____ Donation Center _____

Report To ☐ Physician ☐ Laboratory ☐ Donation Center ☐ All Contact Person _____

Referring Physician _____
Facility Name _____
Address _____
_____
Phone _____ Fax # _____

Laboratory _____
Address _____
_____
Phone _____ Fax # _____

Bill To ☐ Physician ☐ Laboratory ☐ Donation 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
L01031	_____	☐ CFU – Colony Forming Assay
L01046	_____	☐ Complete Blood Count
L03042	_____	☐ Manual Differential
L01035	_____	☐ Sterility
L05045	_____	☐ Trypan Blue Viability

Item # VD	Quantity	Test Description
L02051	_____	☐ CD34/Viability
		WBC _____ Vol. _____ Pt. Wt. _____
L01030	_____	☐ CD3
	_____	☐ Prescreen IDM Testing
		Draw Date: _____

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