F40 PRESCRIPTION FOR STEM CELL AND LYMPHOCYTE COLLECTION

☐ **HPC, Marrow** Please select choice ☐ **HPC, Apheresis** ☐ **MNC , Apheresis**

PATIENT DATA	
Patient name:	
Patient registry:	
Transplant center:	
Patient ID: (assigned by patient registry)	Patient ID: (assigned by donor registry)

DONOR DATA
Donor registry:
Donor ID:
GRID number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐

PRE-COLLECTION ADDITIONAL SAMPLES			
Are pre-collection samples required? ☐ Yes ☐ No			
Sample type:	ml heparin	ml EDTA	ml ACD
	ml no anticoagulant	ml other:	

SAMPLES TO BE SHIPPED TO:	
Institution:	Attention:
Address:	Phone:
	Fax:
ZIP code:	Email:
City:	**Note:** This sample will be shipped at the time of the donor physical exam unless otherwise requested.
Country:	

STEM CELL AND/OR LYMPHOCYTE COLLECTION	
Product type:	
Cell type:	
Required cells/kg	
x Patient weight (kg)	
= Total number of cells	
+ Cells for quality assurance testing	
= Total number of cells	
Please provide explanation for high number of cells:	Please provide explanation for high number of cells:
IRB/Ethics board approval (or equivalent): Date: (YYYY-MM-DD)	IRB/Ethics board approval (or equivalent): Date: (YYYY-MM-DD)

WMDA

Reset Form

F40 PRESCRIPTION FOR STEM CELL AND LYMPHOCYTE COLLECTION

☐ **HPC, Marrow** Please select choice ☐ **HPC, Apheresis** ☐ **T-Cells, Apheresis**

PATIENT DATA	
Patient name:	
Patient ID: (assigned by patient registry)	Patient ID: (assigned by donor registry)

DONOR DATA
Donor registry:
Donor ID:
GRID number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐

ADDITIONAL SAMPLES TO ACCOMPANY STEM CELL OR LYMPHOCYTE PRODUCT
Peripheral blood samples:
ml heparin ml ACD ml EDTA ml no anticoagulant
ml product tube, type: ml other:
Samples to be taken on collection day:
Additional comments:

TRANSPORT DATA	
Product type:	Product type:
Required anticoagulant:	Required anticoagulant:
☐ Heparin	☐ Heparin
☐ EDTA	☐ EDTA
☐ ACD	☐ ACD
☐ Other:	☐ Other:
Donor plasma required? ☐ Yes ☐ No	Donor plasma required? ☐ Yes ☐ No
If yes, please indicate the desired final concentration:	If yes, please indicate the desired final concentration:
Transport temperature:	Transport temperature:
Preferred method of overnight storage of product(s) (if needed):	Preferred method of overnight storage of product(s) (if needed):
Additional instructions:	Additional instructions:

F40 PRESCRIPTION FOR STEM CELL AND LYMPHOCYTE COLLECTION

PATIENT DATA	
Patient name:	
Patient ID: (assigned by patient registry)	Patient ID: (assigned by donor registry)

DONOR DATA
Donor registry:
Donor ID:
GRID number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐

PICK UP PREFERENCE
Pick up preference, if one apheresis is sufficient: ☐ *Pick up at the end of the first collection day* ☐ *No pick up preference*
Comments:

DISCLAIMER:

- The cell products collected from this donor are intended solely for the purpose of immediate therapeutic treatment for the above mentioned patient.Any planned cryopreservation of the cell products prior to initial infusion to the patient may only occur with the advance written approval from the donor center .
- Excess cells may be stored for future therapeutic treatment for this patient. No other uses of these cells are permissible. Cells not used for the therapeutic treatment of the above mentioned patient must be disposed of properly and details must be provided to the donor center.
- The donor center must be provided detailed information concerning the use and/or disposal of all portions of this cell product. By accepting these cells, the transplant physician also accepts these terms and conditions. Deviations from these terms are not permitted without prior written approval from the donor center.
- Any serious product events and/or adverse reactions must be reported both to the donor's registry and transplant center. Corresponding S(P)EAR reports must be completed by the registry providing the product, submitted to the WMDA office and details must provided to the donor center.

Person completing form:	Date (YYYY-MM-DD):	Signature: