Welsh Bone Marrow Donor Registry (WBMDR)

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PRESCRIPTION FOR HUMAN BONE MARROW COLLECTION

(To be completed by the transplant center)

Patient name:	Patient ID number: (assigned by patient's registry)
Transplant center:	Patient ID number: (assigned by donor's registry)
Donor ID number:	GRID:
Donor registry: **WBMDR**	

PRE-COLLECTION PERIPHERAL BLOOD SAMPLES *(maximum 50 mls)*:

	mls EDTA		mls ACD	Other, please specify:
	mls Heparin		mls no anticoagulant	

Samples to be shipped to: Name: Address: **NOTE:** This blood will be shipped at the time of the donor physical exam unless otherwise requested.	**Invoice(s)** to be sent to: Name: Address: **NOTE:** All invoices associated with the blood sample procurement / shipment, donor work-up and stem cell collection should be sent to this address for payment **(list only the requesting hub's address).**
Phone no:	Phone no:
Fax no:	Fax no:
Email:	Email:

MARROW COLLECTION

Required nucleated cells / kg (uncorrected)	X 10^8/kg
x recipient weight (kg)	kg
= total nucleated cells for recipient (uncorrected)	X 10^8
+ nucleated cells for quality assurance	X 10^8
= Total nucleated cells	**X 10^8**
IRB / Ethics Board (or equivalent) Approval	(Yes/No/Not Applicable or Date)

DISCLAIMER: The cell products collected from this donor are intended solely for the purpose of immediate therapeutic treatment for the above mentioned patient. Excess cells may be stored for future infusion 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. 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. Requests for deviations from these terms must be submitted in writing to the donor center for approval.

Required anticoagulant: Heparin ________u/mls ACD _________vol ACD/vol BM Other (please specify):
Required media for marrow transportation:
Transport Temperature: (Special packing materials such as gel packs must be provided by the transplant center unless alternative arrangements have been made with the donor or collection center)

PERIPHERAL BLOOD SAMPLES TO BE COLLECTED AT TIME OF COLLECTION *(maximum 50 mls)*

	mls EDTA		mls ACD		mls Product Sample
	mls Heparin		mls no anticoagulant	Other:	
Additional comments:					

Transplant physician:	Signature:	Date: (Day/Month/Year)