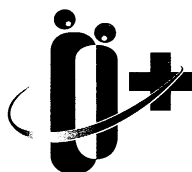

Marrow Donor Program Belgium - Registry
Motstraat 40 2800 Mechelen
Tel: (32) - 15 44 33 96 Fax: (32) - 15 44 36 56
Email : MDPB-registry@rodekruis.be

VERIFICATION OF CELL PRODUCT – HUMAN PERIPHERAL BLOOD LYMPHOCYTE
(TC, Apheresis)

Patient name:	Patient ID number: (assigned by patient's registry)	Patient weight: (kg)
Transplant center:	Patient ID number: (assigned by donor's registry)	
Donor registry:	Donor ID#:	Donor weight: (kg)

This form must be completed by the donor center and the collection center and returned to the requesting registry. The requesting registry will forward the completed form to the transplant center for verification. A copy of the fully completed and signed form will be returned to the donor and collection centers.

SECTION A: TO BE COMPLETED BY THE DONOR CENTER

Human Peripheral Blood Lymphocyte Collection	
Total number of CD3+ cells **requested** by TC* and/or: **Total** number of Mononuclear cells (MNC) **requested** by TC*	X 10^8 X 10^8
* Please transfer the Total number of CD3 + cells and/or MNC listed on the **Prescription for Human Peripheral Blood Lymphocyte Collection** provided by the Transplant center.	
Comments:	
Donor Center Signature:	Date: (Day/Month/Year)

SECTION B: TO BE COMPLETED BY THE COLLECTION CENTER

Collection Center Name:	**Peripheral Blood Lymphocyte Collection** DATE OF COLLECTION (Day/Month/Year)		**Peripheral Blood to be collected at the time of Lymphocyte collection**
Address:	Total number of CD3 + cells that may be collected? ** and/or : Total number of MNC that may be collected **	X10^8 X10^8	☐ mls Heparin ☐ mls ACD ☐ mls EDTA ☐ mls no anti-coagulant ☐ mls Product Sample
Telephone: Fax: Email:	Anticoagulants and medium used: ☐ Heparin ☐ ACD ☐ Other		Comments:
Contact Person:			
Based on the experience at this collection center, I feel that the requested number of CD3 + cells is: ☐ FEASIBLE ***NOTE:*** ***This is not a guaranty that the requested number of cells will be supplied. The number of cells collected may be larger or smaller.*** ☐ NOT FEASIBLE Comments:			
Collection Center Signature:			Date: (Day/Month/Year)

SECTION C: TRANSPLANT CENTER ACCEPTANCE OF TERMS PROVIDED BY DONOR & COLLECTION CENTERS

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.

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