



Marrow Donor Program Belgium - Registry
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**PRESCRIPTION FOR STIMULATED HUMAN PERIPHERAL BLOOD STEM CELL COLLECTION
(HPC, Apheresis)**

(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 registry:	Donor ID number:

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:		

STIMULATED PBSC COLLECTION:

Required CD34 pos. cells / kg	X 10 ⁶ /kg
X recipient weight (kg)	kg
= total number of CD34 pos. cells	X 10 ⁶
+ CD34 pos. cells for quality testing	X 10 ⁶
= total number of CD34 pos. cells	X 10 ⁶
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.

Preferred method of overnight storage (if needed) of apheresed product(s):	Donor Plasma Requirements: (<input type="checkbox"/> Yes <input type="checkbox"/> No) If Yes, amount:
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)	
Additional comments:	

PERIPHERAL BLOOD SAMPLES TO BE COLLECTED AT FIRST APHERESIS (maximum 50 mls)

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

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