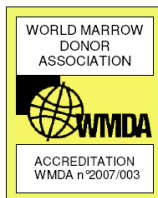


n° : _____ Date: ____/____/____



*Prescription
for human
bone marrow collection*

To be completed by the Transplant Centre

Patient name:	
TC IBMDR code:	Donor ID code:

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:				
Contact name:				
Phone n°: +39-				
Fax n°: +39-				

MARROW COLLECTION:

Required Nucleated Cells/kg	X 10 ⁸ /kg*
x recipient ideal weight (kg)	kg
= Total Nucleated Cells for recipient	X 10 ⁸
+ Nucleated cells for quality assurance	X 10 ⁸
= Total Nucleated Cells	X 10 ⁸

* could not exceed: 6 x 10⁸/Kg

DISCLAIMER. The cell products collected from this donor are intended solely for the purpose of immediate therapeutic treatment for the above mentioned patient and could not be criopreserved. By accepting these cells, the transplant physician also accepts these terms and conditions.

Required anticoagulant: Heparinu/mls ACDvol ACD/vol BM
Other (specify):.....
Required media for marrow transportation:

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

	mls EDTA		mls ACD	Other (specify):
	mls Heparin		mls no anticoagulant	
Additional requirements:				

Person Completing Form:	Signature:	Date:.....
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