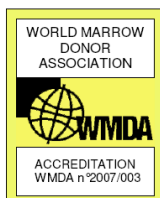


n° : _____ Date: ____/____/____



*Prescription
for stimulated human
peripheral blood stem cell
collection*

To be completed by the transplant centre:

Patient name:	
CT IBMDR code:	Donor code:

PRE-COLLECTION PERIPHERAL BLOOD SAMPLES (maximum 100 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-			

STIMULATED PBSC COLLECTION:

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

* could not exceed: 5 x 10⁶/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 cryopreserved. By accepting these cells, the transplant physician also accepts these terms and conditions.

Preferred method of overnight storage (if needed) of apheresis product(s):
--

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

Samples:	I day's collection	II day's collection
EDTA	mls	mls
Heparin	mls	mls
ACD	mls	mls
no anticoagulant	mls	mls
Other, please specify	mls	mls

Transplant physician:	Signature:	Date:
-----------------------	------------	-------