



*Prescription  
for stimulated human  
peripheral blood stem cell  
collection*

To be completed by the transplant centre:

Patient ID:	CT IBMDR code:
Donor GRID:	

**PRE-COLLECTION PERIPHERAL BLOOD SAMPLES** (maximum 30 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 <sup>6</sup> /kg*
X recipient ideal weight (kg)	kg
= total number of CD34+ cells	X 10 <sup>6</sup>
+ CD34+ cells for quality testing	X 10 <sup>6</sup>
= total number of CD34+ cells	X 10 <sup>6</sup>

\* could not exceed: 5 x 10<sup>6</sup> /Kg. If higher, please specify the reason. The CC will provide the maximum quantity that could be collected not proceeding with a second apheresis if the target of 5 x 10<sup>6</sup> /Kg is reached in the first day of collection:.....

**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 (unless a donor bone marrow back-up could not be available in case of poor mobilization). Excess cells may be stored only for future therapeutic treatment for the same patient. IBMDR must be provided detailed information concerning the use and/or disposal of all portions of this cell product. Deviations from these terms are not permitted without prior written approval from IBMDR. The TC shall inform IBMDR in case of any adverse event occurred to the patient or product. By accepting these cells, the transplant physician also accepts these terms and conditions.

Required anticoagulant:.....	
Specify PBSC transport conditions:	
Room temperature	Cooled (2-8 °C)
Preferred method of overnight storage (if needed) of apheresis product(s):	
.....	

**PERIPHERAL BLOOD SAMPLES TO BE COLLECTED AT TIME OF COLLECTION** (maximum 30 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:
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