MRI Number

HAEMATOPOIETIC STEM CELL SPECIMEN REQUEST FORM

SANBS
Registration No. 2000/026390/08

Name and Surname		DOB/ ID		Gender	M
					F
Hospital and Ward		File No.			
Diagnosis		Attending Physician			
Product ISBT number					
Product code					

CLINICAL INFORMATION:

Recipient (Ideal) Weight	_____kg					
Bag Volume	Product:	_____ml	Plasma:	_____ml	TBV	
Specimen collection	Date:		Time:			
Type of Procedure Collection	☐ Autologous		☐ Allogeneic			

COMMENT:

Product Specimen sent to:	☐ CTL ☐ QC ☐ OTHER **If other, provide name:**			
Person collecting specimen from clinical facility:	Name and Surname:		Signature:	
	Date		Time	
Person handing over specimen:	Name and Surname:		Signature:	
Person receiving specimen:	Name and Surname:		Signature:	
Date and Time specimen was received:	Date		Time	

Test requested	Attach Specimen Barcode Label
Pre $CD34^+$	
Mid Harvest $CD34^+$	
End Harvest $CD34^+$	
WCC and Diff	
Pre-Sterility (Pre-Bone Marrow Processing)	
Post-Sterility	
Post-FBC	
Final Bag $CD34^+$ (Bone Marrow Processing)	
Preliminary Bag $CD34^+$ (Pre-Bone Marrow Processing)	
Preliminary Bag $CD34^+$ and FBC (Post-Bone Marrow Processing)	
$CD3^+$	
Mid $CD3^+$	

For Any Queries Contact STS: STS Callphone: **082 555 9294**
Email: **TherapeuticsAdmin@sanbs.org.za**