

MRI Number

HAEMATOPOIETIC STEM CELL SPECIMEN REQUEST FORM



PATIENT / DONOR INFORMATION:

Name and Surname		DOB/ ID		Gender	M	
					F	
Hospital and Ward		File No.				
Diagnosis		Attending Physician				
Product Bag Label						

TEST(s) REQUESTED: Pre-CD34+ Mid-Harvest CD34+ End-Harvest CD34+ WCC and Diff Sterility
 FBC (Fresh Product) Post-FBC Transfer Bag CD34+ (Bone Marrow Processing)
 CD3+ Mid-CD3+ CD45+

CLINICAL INFORMATION:

Recipient Weight:						
	kg					
Bag Volume (ml):	Product:		Plasma:			
		ml		ml		
Date and Time specimen was collected:	Date:		Time:			
Autologous / Allogeneic:	<input type="checkbox"/> Autologous			<input type="checkbox"/> Allogeneic		

COMMENT:

Product Specimen sent to:	<input type="checkbox"/> CTL <input type="checkbox"/> QC <input type="checkbox"/> OTHER					
	Provide name:					
Person collecting specimen from clinical facility (if applicable):	Name and Surname:			Signature:		
Person handing over specimen:	Name and Surname:			Signature:		
Contact details (SANBS):	Name and Surname:			Contact numbers:		
Date and Time specimen was sent:	Date:		Time:			

Test requested	Attach Specimen Barcode Label
Pre CD34+	
Mid Harvest CD34+	
End Harvest CD34+	
WCC and Diff	
Sterility	
FBC Product (FRESH)	
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+	
CD45+	