PROCESSING REQUEST OF PRODUCT FOR CLINICAL USE (CLIN-F-017C)
(Cellular and Immunotherapy Centre)

SANBS
Registration No. 2000/026390/08

Patient safety: the availability of cryopreserved products must be confirmed in writing between the Stem Cell Laboratory and the referring Consultant **before the patient commences conditioning** therapy. Send completed form at least 3 working days before commencement of conditioning therapy to: SANBS.

STEM CELL DONOR							
Title		**Surname**		**Name**			
Gender	☐M ☐F	**ID/DOB**		**Height**	cm	**Weight**	kg
Blood Group		**Contact number**		**Email Address**			

STEM CELL TRANSPLANT RECIPIENT ☐ **AUTOLOGOUS** ☐ **MRD** ☐ **MUD** ☐ **HAPLO**					
Title		**Surname**		**Name**	
Gender	☐M ☐F	**ID/DOB**		**Height**	cm
Weight	kg	**Calculated Adjusted Body Weight (if applicable i.e.: BMI > 30 kg/m²)**	kg	**Use Adjusted Body Weight instead of actual weight**	☐ YES ☐ NO
Blood Group		**Contact number**		**Diagnosis**	
Med Aid		**Med Aid number**		**E-mail Address**	

Conditioning	**TBI / TNI**	☐ YES ☐ N	**Start Date**		**Chemo**		**Start Date**	

PROCESSING REQUEST					**DATE**		
Product	☐ Allogeneic	☐ Autologous	☐ Single SCT	☐ Double SCT	☐ DLI	☐ TPE	☐ Granulocytes
Collection Type	☐ HPC, Apheresis		☐ HPC, Marrow		☐ TC-T cells		
Cell Modification	☐ None	☐ Cryo- preservation			☐ Red Cell Depletion	☐ Volume Reduction	
	☐ Campath	Dose:			☐ Pool Multiple Bags for Fresh SCT		
Additional microbiology testing		**CFU assay required**			**Additional flow cytometry markers** ☐ Myeloma ☐ MSC ☐ Other		
Additional information:							

Transplant Physician: _____ **Date:** _____

SANBS use only

Processing information confirmed by CTL Head of Lab/ designate YES/NO

Name_____Signature_____Date _____