## REQUEST FOR DONOR LYMPHOCYTE REINFUSION



Donor	ed by Clinic	ai Ulilli.	Pos	pient	
Title		Title	pieni		
Name and Su	ırnama			ne and Surname	
DOB/ID	mame		DOB		
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Hospital Hospital num	hor	Hospital Hospital number			
Blood Group	Jei	Blood Group			
Physician		Physician			
Contact Details				tact Details	
Coniaci Dei	כווג			ent diagnosis	
				ent disease statu	2
o be complet	ed by Clinic	al Unit:	Con	em disease sidio	3
Procedure		us offit. Issue to transplant	Centre 🗀	Thaw at the bed	side Transfer elsewhere
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known)			LOCK	anorreguled	
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roduct Inform	ation:				
To be comple					Clinical Facility
Unit number			CD3	Sterility	Tick products to be releas
	date	CD3 dose	viability	Sieriniy	lick products to be releas
	uuic		Viability		☐ Yes☐ No
					1031110
					☐ Yes☐ No
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