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:	_______ml	Plasma:	_________ml
Date and Time specimen was collected:	Date:		Time:	
Autologous / Allogeneic:	☐ Autologous		☐ Allogeneic	

COMMENT: ....

....

Product Specimen sent to:	☐ CTL ☐ QC ☐ 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 $CD3^+$	
$CD45^+$	