Cellular Therapy Product Request

Requesting Facility: ☐ Froedtert Hospital ☐ Children's Hospital ☐ Advocate Aurora St. Luke's Medical Center

Collection Start Date: _____

Product Type Requested

☐ HPC, Mobilized; Target Dose: _____ x 10^6 CD34/kg
- ☐ Clinical/Research: List Sponsor and Protocol Name: _____

☐ MNC, Non-mobilized; Target Dose, if applicable: _____
- ☐ Commercial: List Company and Product Name: _____
- ☐ Clinical/Research: List Sponsor and Protocol Name: _____

☐ Collection of one unit of Whole Blood, stored at 20-24º C

Autologous Donor or Recipient Information

Apply Label for Autologous Donor/Recipient or complete:

Name: _____

DOB: _____

Medical Record Number: _____

Diagnosis: _____

Sex: ☐ M ☐ F ABO/Rh: _____ ☐ N/A- Auto Donor

Height: _____ Weight: _____ kg

Is the patient allergic to heparin? ☐ YES ☐ NO

Allogeneic Donor Information (N/A for Auto Donors)

Apply Label for Allogeneic Donor or complete:

Name: _____

DOB: _____

Medical Record Number: _____

Sex: ☐ M ☐ F ABO/Rh: _____

Height: _____ Weight: _____ kg

Is there a signed consent on file? ☐ YES ☐ NO

Has donor or family been made aware of the availability of a donor advocate? ☐ YES ☐ NO

Donor Information and Records

1. **All Donors:** Are there communication barriers or issues that pertain to the safety of the collection procedure?
   ☐ YES* ☐ NO *If yes, describe: _____
   _____

Questions 2-4 - Complete for HPC Collections Only

2. Female Donors Only: Date Pregnancy Test was completed: _____ ☐ N/A- Not indicated
3. Date Hemoglobinopathy assessment was completed: _____
4. Start Date of planned mobilization regimen: _____ Mobilization Regimen: ☐ G-CSF ☐ Plerixafor ☐ Chemo

Vascular Access Information

Vein Assessment Performed by: _____ Date: _____

☐ Peripheral veins acceptable ☐ Ultrasound Guided Peripheral Access (schedule back-up Central Line appt.)

☐ Central Venous Catheter Type of Line: _____ Line Insertion Date/Time: _____

Authorization Signatures

Form Completed by: _____ Ordering Physician: _____

Ordering Physician Signature: _____ **Date:** _____

Versiti Physician Signature: _____ **Date:** _____

Send the Autologous Donor Suitability Determination or the Allogeneic Donor Eligibility Determination with this form to: SPSAlerts@versiti.org or Fax to 414-933-6833.
For questions call 414-937-6189