BMT Infusion Request

Spectrum Health:
◯ Adult BMT ◯ Pediatric BMT

Infusion Request - Completed by Transplant Center

Insert Hospital Label for **Recipient** or Complete:

Name _____
DOB _____
MR# _____

Recipient ID _____ or ☐ NA
Recipient ABO/Rh _____
Recipient Wt (kg) _____

Insert Hospital Label for **Donor** or Complete:

Name or DID _____
DOB _____ or ☐ NA
MR# _____ or ☐ NA

◯ Auto- Donor Info Not Applicable
Donor ABO/Rh _____
Donor Wt (kg) _____ or ☐ NA

◯ Unit ID Requested _____ or ◯ See attached Cryopreservation Report (requires physician signature)

Requested Date/Time of Infusion _____ Collection Date _____

Component Requested: ◯ BM ◯ PBSC ◯ Cord ◯ DLI ◯ Other:_____

Requested Transport Temp: ☐ RT (15-25°C) ☐ Cool (1-10°C) ☐ Cryopreserved (≤-150°C)

Processing Requested: ☐ Lab Thaw/Wash ☐ Bedside Thaw ☐ Plasma Depletion ☐ No manipulation
☐ Lab Thaw/Dilute (CBU) ☐ Buffy Coat Enrichment ☐ RBC Depletion (BM)

Requesting Physician Signature _____ Date _____

Infusion Component - Completed by CTL Staff

Unit ID: _____ _____ of _____

Component Name _____ (*serologic compatibility test **NOT** performed*)

☐ **Bedside Thaw**
Total WBC _____ x 10^8
WBC/kg _____ x 10^8
CD34/kg _____ x 10^6
CD3/kg _____ x 10^7
Final infusion volume _____ ml
RBC volume at cryopreservation _____ ml

☐ **Other Infusions**
Total Viable WBC _____ x 10^8
Viable WBC/kg _____ x 10^8
Final Viable WBC Recovery _____ %
CD3/kg _____ x 10^7
CD34: vCD34/kg _____ x 10^6 CD34/kg _____ x 10^6
Final infusion volume _____ ml
Final RBC volume _____ ml

Inspection/Verification - Completed by CTL Staff and Transplant Center Infusion Staff

Delivered component ID matches requested component unit ID?: ☐ Yes ☐ No
Container/unit integrity/appearance all normal and acceptable?: ☐ Yes ☐ No
Transplant Center Nurse _____ (signature) Cellular Therapy Lab Tech _____ (signature)

Infusion Data - Completed by Transplant Center Infusion Staff

ID Verification
Patient and unit ID confirmation:
(verified in the presence of the patient)
Checked by: _____
Confirmed by: _____

Infusion Lot Numbers
Infusion Set _____ Exp _____
0.9% NaCl _____ Exp _____

Infusion
Date/Time Infusion Started: _____
Date/Time Infusion Completed: _____
Pre txn vitals (T,P,R) _____ BP _____
Post txn vitals (T,P,R) _____ BP _____
Adverse Reaction: ☐ No ☐ Yes
Completed by: _____ Date: _____

Comments: _____
TC physician review: _____ Date: _____

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Please fax completed form to 616-233-8559

Previous # 27712

Document No:	MB.CTL.FM-0001
Version:	7.0