BMT Infusion Request

1036 Fuller Ave NE Grand Rapids, MI 49503
Ph: 616-233-8598 Fax: 616-233-8559

Recipient

Completed by Transplant Center

Insert Hospital Label for Recipient or Complete:

Name _____

DOB _____ MR# _____

Spectrum Health: ◯ Adult BMT ◯ Pediatric BMT

NMDP Recipient ID _____ or ☐ NA

ABO/Rh _____ Wt (kg) _____

Donor

Insert Hospital Label for Donor or Complete:

Name or NMDP DID _____

DOB _____ or ☐ NA

Medical Record # _____ or ☐ NA

◯ Auto- Donor Info Not Applicable

◯ Allo

ABO/Rh _____

Wt (kg) _____ or ☐ NA

Infusion Request

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

☐ NMDP DID Requested _____ Draw Date _____

Requested Date/Time of Infusion _____

Component Requested (check one): ◯ BM ◯ PBSC ◯ Cord ◯ DLI ◯ Other: _____

Processing Requested: ☐ Laboratory Thaw/Wash ☐ Bedside Thaw ☐ Plasma Depletion ☐ No manipulation ☐ Laboratory Thaw/Dilute (CBU) ☐ Buffy Coat Preparation ☐ 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 _____ x 10^8

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 _____ Michigan Blood Tech _____

(signature) (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: _____

Please fax completed form to 616-233-8559.

Previous # 27712

Document No:	MB.CTL.FM-0001
Version:	5.0