Versiti | Blood Center of Michigan
1036 Fuller Ave NE | Grand Rapids MI 49503
CLTfax 616.233.8559 **THERfax** 616.233.8671

PBSC/Lymphocyte Collection and Processing Order

☐ Corewell Health ☐ HDVCH ☐ Other _____

Recipient

Affix Recipient Hospital Label or Complete:
Name: _____
DOB: _____
MRN: _____

Sex: ☐ Male ☐ Female ABO/Rh: _____
Height (cm): _____ Weight (kg): _____
Diagnosis: _____
Allergies: _____ ☐ NKA

Donor

Affix Donor Hospital Label or Complete:
Name: _____
DOB: _____
MRN: _____

☐ NA-Autologous Product
Sex: ☐ Male ☐ Female ABO/Rh: _____
Height (cm): _____ Weight (kg): _____
Allergies: _____ ☐ NKA

Access

Peripheral access adequate: ☐ Yes ☐ No Central catheter: ☐ Yes ☐ No
Type and Location: _____ Date placed/to be placed: _____

Donor Records

1. Is there a signed consent on file? ☐ Yes ☐ No
2. Has donor medical and behavioral history been evaluated? ☐ Yes ☐ No
3. Are there any issues that pertain to the safety of the collection procedure? ☐ Yes ☐ No
   If yes, describe: _____
4. Has the donor been evaluated for the risk of hemoglobinopathy? ☐ Yes ☐ No
5. Has a copy of the donor's H and P, medication list, and labs been attached? ☐ Yes ☐ No
6. Has pregnancy assessment been performed (or will be performed) within 7 days of donor's mobilization and, as applicable, within 7 days prior to initiation of recipient preparative routine? (NA-donor not of child-bearing potential) ☐ Yes ☐ No ☐ NA
7. Has allogeneic donor eligibility been determined prior to the donor beginning their mobilization regimen? (NA-autologous donor) ☐ Yes ☐ No ☐ NA
8. Has donor or family been made aware of the availability of a donor advocate? ☐ Yes ☐ No

Collect

Anticipated collection date/time: _____

☐ PBSC: desired CD34 dose _____ 10^6/kg
☐ DLI: desired CD3 dose _____ 10^7/kg
☐ Other: _____

Processing

Versiti Michigan Cellular Therapy Lab to process product. Transport from collection center to processing laboratory is room temperature (15-25°C) unless otherwise indicated. ☐ Other _____ °C
Anticipated infusion date: _____

PBSC (check all that apply)

☐ Process for immediate infusion. See BMT Infusion Request for additional processing instructions.
☐ Process for freezing and storage.
☐ Perform CD3 assay and store DLI aliquots based on CD34/CD3 counts; See BMT - Administration of DLIs SOP.
   ☐ Related, matched ☐ Related, haplo
☐ Plasma/volume reduction: Target _____ ml

Lymphocyte (check all that apply)

☐ Process to infuse fresh Aliquot 1, freeze remaining aliquots; See BMT - Administration of DLIs SOP.
   ☐ Related, matched ☐ Related, haplo
☐ Process and freeze all aliquots.
☐ Other: _____
_____

Authorization

Ordering Physician (print): _____ Signature: _____ Date: _____

Email completed form to GV_TherapeuticAdmin@miblood.org

Versiti Michigan Provider Signature: _____ Date: _____