Versiti | Blood Center of Michigan
1036 Fuller Ave NE | Grand Rapids MI 49503
p 616.233.8598 f 616.233.8559 w versiti.org

versiti™

BMT Infusion Request

☐ Corewell Health ☐ HDVCH ☐ Other: ____________

Product Request Order

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

Recipient ID: ____________ or ☐ NA
Recipient ABO/Rh: ________
Recipient Wt (kg): ________

Affix Donor Hospital Label or Complete:
Name/GRID: ____________
DOB: ____________ or ☐ NA
MRN: ____________ or ☐ NA

☐ NA - Autologous Product
Donor ABO/Rh: ________
ABO Compatibility: ☐ Compatible ☐ Major Incompatibility ☐ Minor Incompatibility

Product Requested: ☐ HPC, Apheresis ☐ HPC, Marrow ☐ HPC, Cord Blood ☐ T Cells, Apheresis ☐ Other: ____________

Dosage Requested: ☐ CD34 _____ x 10^6/kg ☐ TNC _____ x 10^8/kg ☐ CD3 _____ x 10^7/kg

Requested Date/Time of Infusion: ____________ (Date) ________ (Time)

Requested Unit(s) for Infusion:

DIN: ____________ Aliquot(s): ________

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

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

Comments: ____

____

Requesting Provider: ____________ (Signature) Date/Time: ____________

Send completed form to: Email CTL@versiti.org or Fax (616) 233-8559

Inspection & Verification at Delivery

☐ NA- Chain of Custody documented on other forms.

Delivered product DIN matches requested product DIN for each unit listed above? ☐ Yes ☐ No

Container, unit integrity, and appearance normal and acceptable for each unit listed above? ☐ Yes ☐ No

Comments: ____

Nurse: ____________ (Signature) Date: ________ Time: ________

Tech: ____________ (Signature) Date: ________ Time: ________

DIN = Donor Identification Number

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