Cellular Therapy Product Collection Request

Instructions: The requesting provider or designee is responsible for completing all fields of this form. The Versiti provider is responsible for reviewing the order. Please scan or fax the completed form using state specific contact information below with the Autologous Donor Suitability Determination or the Allogeneic Donor Eligibility Determination and supporting documents.

State	Address	Email	Phone	Fax
Wisconsin	638 N. 18th St, Milwaukee, WI, 53233	WI-CellCollection@versiti.org	414-937-6154	414-933-6833
Michigan	1036 Fuller Ave NE, Grand Rapids, MI 49503	MI-CellCollection@versiti.org	616-233-8569	616-233-8671
Indiana	3450 N. Meridian St, Indianapolis, IN 46208	IN-CellCollection@versiti.org		

Requesting Facility: **Tentative Collection Start Date:**

AUTOLOGOUS DONOR/ALLOGENEIC RECIPIENT INFORMATION

Apply Hospital Label or complete:

Donor/Recipient Name:

Date of Birth:

Medical Record #:

Diagnosis:

Sex: ☐ M ☐ F **ABO/Rh:**

Height: ☐ inches ☐ cm

Weight: kg

ALLOGENEIC DONOR INFORMATION (DO NOT COMPLETE FOR AUTOLOGOUS DONORS)

Apply Hospital Label or complete:

Donor Name:

Date of Birth:

Medical Record #:

Sex: ☐ M ☐ F **ABO/Rh:**

Height: ☐ inches ☐ cm **Weight:** kg

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

PRODUCT TYPE

☐ HPC, Apheresis: Target Dose: x 10^6 CD34/kg ☐ MNC, Apheresis

COMMERCIAL OR CLINICAL PROTOCOL, IF APPLICABLE

☐ **Commercial:** List Company/Product Name:

☐ **Clinical/Research:** List Sponsor/Protocol Name:

DONOR INFORMATION AND RECORDS

All DONORS: Are there communication barriers or issues that pertain to the safety of the collection procedure?

☐ YES* ☐ NO *If yes, describe:

ALL DONORS: Vein Assessment Performed by: ☐ Peripheral veins acceptable

☐ Central Venous Catheter (CVC) ☐ Ultrasound Guided Peripheral Access (schedule back-up CVC appt.)

ALL DONORS: Is there a signed consent on file? ☐ YES ☐ NO

Female Donors Only: Date Pregnancy Test was completed: ☐ N/A- Not indicated

HPC Donors Only: Date Hemoglobinopathy assessment was completed:

HPC Donors Only: Start Date of planned mobilization regimen:

PROCESSING ORDER, IF APPLICABLE

Tentative Infusion Date: ☐ Process for Fresh Infusion ☐ Process for cryopreservation and storage

☐ Allogeneic Products Only: Perform CD3 counts. Prepare product for Donor Lymphocyte Infusion if counts are sufficient. Plasma Depletion or Volume Reduction per Versiti policy.

AUTHORIZATION SIGNATURES

Form Completed by: Ordering Provider:

Ordering Provider Signature: **Date:**

Versiti Provider Signature: **Date:**