

Cellular Therapy Product Processing Request

Recipient Information:

Affix Hospital Label or complete:
 Name _____
 DOB _____
 MRN _____

Corewell Health CHN Other _____
 Wt _____ kg ABO/Rh _____ Diagnosis _____
 Recipient ID _____ NA
 Ordering Physician _____

Donor Information: NA (Autologous)

Name/GRID _____ MRN _____ NA ABO/Rh _____
 Unrelated, Matched Unrelated, Mismatched Related, Matched Related, Haplo

Product Information:

HPC, Apheresis HPC, Marrow MNC, Apheresis HPC, Cord Blood Other _____
 Imported from: NA (Versiti) NMDP Other _____ DIN/Local ID _____ NA
 Anticipated collection date: _____
 HPC, Apheresis: Expected CD34 dose _____ x10⁶/kg
 DLI: Expected CD3 dose _____ x10⁷/kg
 HPC, Marrow: Expected TNC Dose _____ x10⁸/kg
Expected CD34 Dose _____ x10⁶/kg

Processing Request: (check all that apply)

<p style="text-align: center;"><u>HPC, Apheresis</u></p> <p>Autologous <input type="checkbox"/> Process for cryopreservation and storage</p> <p>Allogeneic <input type="checkbox"/> Process for immediate infusion <input type="checkbox"/> Plasma Depletion <input type="checkbox"/> No manipulation <input type="checkbox"/> Perform CD3 testing only <input type="checkbox"/> DLI storage (includes CD3 testing) <input type="checkbox"/> Process for cryopreservation and storage <input type="checkbox"/> Plasma Depletion <input type="checkbox"/> Perform CD3 testing only <input type="checkbox"/> DLI storage (includes CD3 testing)</p> <p style="text-align: center;"><u>Frozen Products</u></p> <p><input type="checkbox"/> Hold and store for future use CBU RBC depleted <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p style="text-align: center;"><u>HPC, Marrow</u></p> <p><input type="checkbox"/> No manipulation <input type="checkbox"/> Buffy coat enrichment <input type="checkbox"/> Process for cryopreservation and storage</p> <hr/> <p style="text-align: center;"><u>MNC, Apheresis (DLI)</u></p> <p><input type="checkbox"/> See clinical program SOP for dose aliquots <input type="checkbox"/> Process to infuse fresh aliquot and freeze remaining aliquots <input type="checkbox"/> Process for cryopreservation and storage <input type="checkbox"/> Other _____</p> <p>Comments: _____ _____</p>
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Ordering Physician Signature: _____ Date: _____ Time: _____

Fax to Cellular Therapy Lab (616 233-8559) or email to CTL@versiti.org

CTL Use Only:

Confirmation of space availability and proper temperature for storage:

Storage Location	Storage Temperature	Verified By	Date
	<input type="checkbox"/> 1-10°C <input type="checkbox"/> 15-25°C <input type="checkbox"/> ≤-150°C		