

CB30

CORD BLOOD UNIT SHIPMENT REQUEST

Page 1 of 2

PATIENT DATA			
Patient first name:		Patient last name:	
Patient registry:			
Transplant centre:			
Patient ID: <small>(assigned by patient registry)</small>		Patient ID: <small>(assigned by donor registry)</small>	
Date of Birth: (YYYY-MM-DD)	Gender:	Weight: (kg)	Blood group/Rh(D):
Diagnosis:		Estimated transplant date: (YYYY-MM-DD)	

PATIENT HLA					
Locus:	A	B	C	DRB1	DOB1
First antigen:					
Second antigen:					
<input type="radio"/> Initial typing		<input type="radio"/> Verification typing		Typing date: (YYYY-MM-DD)	
Cord Blood Unit ID:					

ADDITIONAL PRE-RELEASE CHECKS	
The transplant center requests the following tests to be done on CBU at time of release and/or additional information: Please test the following on post-cryopreservation attached segment of CBU at time of release:	
<input type="checkbox"/> Viability test	<input type="checkbox"/> Colony testing (e.g. CFU-GM)
<input type="checkbox"/> CD34 pos test	<input type="checkbox"/> HLA verification test
<input type="checkbox"/> Additional IDM tests, please specify:	
<input type="checkbox"/> Blood or other sample shipment, please specify:	
<input type="checkbox"/> Maternal health questionnaire or summary statement	
<input type="checkbox"/> Other tests:	

PROPOSED TIME FRAME FOR CORD BLOOD UNIT SHIPMENT	
Preferred date: <small>(YYYY-MM-DD)</small>	Preferred delivery time: <small>(HH:MM + local time zone)</small>
Start of conditioning: <small>(YYYY-MM-DD)</small>	Conditioning regimen: <input type="radio"/> Myeloablative <input type="radio"/> Non-myeloablative
Transplant type: <input type="radio"/> Single cord <input type="radio"/> Double cord <input type="radio"/> Multiple cord <input type="radio"/> Single cord in combination with haplo-donor <input type="radio"/> Ex-vivo expansion transplant <input type="radio"/> Other, please specify:	
Transplant date: <small>(YYYY-MM-DD)</small>	
Comments:	
Transport to be organised by: Dry shipper to be provided by:	Preferred courier:

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Page 2 of 2

PATIENT DATA	
Patient first name:	Patient last name:
Patient ID: <small>(assigned by patient registry)</small>	Patient ID: <small>(assigned by donor registry)</small>

Cord blood unit to be shipped to:	Invoice(s) to be sent to:
Institution:	Institution:
Address:	Address:
ZIP:	ZIP:
City:	City:
Country:	Country:
Attention:	Attention:
Phone:	Phone:
Fax:	Fax:
E-mail:	E-mail:

Person completing form:	Date: (YYYY-MM-DD)	Signature:
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