

HEMATOPOIETIC PROGENITOR CELL REQUEST

Physician _____ Telephone _____ Fax _____

Patient _____
(LAST NAME) (NSFX) Jr. or III (FIRST NAME) (MIDDLE NAME)

Former Last Name(s) _____

DOB _____ Telephone _____

Hemoglobinopathy Risk: Yes No Height _____ Weight _____

Diagnosis _____

Collection Goal _____ x 10⁶ CD34+ cells/kg

Vascular Access Type and Hospital _____

Surgeon _____

***Date to be Placed** _____

**Recommended to be placed no later than one (1) day prior to drawing of first CD34*

Anticipated Collection Date and Hospital _____

Processing/Storage Laboratory INBC Other, please describe why _____

Anticipated Transplant Date and Hospital _____

Chemotherapy Yes No Date Started _____

Growth Factor and Dosage _____ Date Started _____

CD34 Samples to be Drawn _____
(Date)

Special Considerations _____

Physician _____, M.D. Date _____

PLEASE FAX THE COMPLETED FORM: (509) 232-4523

Note to Ordering Physician:

1. Peripheral and collection CD34 results are included in the cost of your patient's HPC collection if samples are sent to INBC Lab.
2. Please notify INBC of CBC and peripheral CD34 results if performed at a Lab other than INBC:
PHONE (509) 624-8591 OR FAX (509) 232-4524
3. Recommended catheters for vascular access (internal jugular placement is preferred).
 - a. Permanent: Hickman Double-Lumen Hemodialysis/Hemapheresis Catheter (13.5 Fr)
 - b. Temporary: Quinton-Mahukar Double-Lumen Catheter (11.5 Fr)

Written X-ray confirmation/or confirmation of C-arm placed catheters is required.