NMDP Prescription for MNC, Apheresis

TC Code: _____ RID: _____ GRID: _____ DID: _____

♦ DO NOT include samples related to a transplant center research study (requiring NMDP IRB approval) on the prescription. Instead, include these research samples on the *Request for NMDP Donor to Participate in a Research Study* form.

PRE-COLLECTION BLOOD SAMPLES

SAMPLE REQUIREMENTS:

_____ mls Red top tube (no anticoagulant)

_____ mls Yellow top tube (ACD)

_____ mls Green top tube (sodium heparin)

_____ mls Purple top tube (EDTA)

Shipping Information

Attn/Name: _____

Center Name: _____

Address Line 1: _____

Address Line 2: _____

City, State, Country, Zip: _____

Telephone: _____

Specify when samples should be collected: _____

CELL DOSE CALCULATIONS

Desired $CD3^+$ cells/kg: _____ x 10^7/kg

Multiply by Recipient weight in kg: x _____ kg

Total $CD3^+$ cells requested: = _____ x 10^7

Multiply by 2 x 2

TOTAL mononuclear cells (TMC) = _____ x 10^7

Divided by 100 x 10^7 TMC/L = _____ Liters processed

- $CD3^+$ content is approximately 50% of Total Mononuclear Cells (TMC).
- Mononuclear cells are calculated from the sum of lymphocytes and monocytes on the standard differential count.
- The average leukapheresis yield is approximately 100 x 10^7 mononuclear cells per liter of blood processed.

A maximum of 24 liters of donor blood will be processed in a single apheresis procedure to accommodate request

Designate transport temperature: ○ Room Temperature ○ Cooled with reusable coolant packs

Will portions of the cells be cryopreserved? ○ NO ○ YES

Will the cells be manipulated prior to infusion? ○ NO ○ YES → Describe: _____

SAMPLES REQUIRED AT TIME OF COLLECTION

Indicate the volume and type of tubes required below. A minimum of **10 mls** of peripheral blood must accompany product and be used for ABO and Rh confirmation.

	Peripheral Blood	MNC(A) Product
Red Tube (No anticoagulant)	_____ mls	_____ mls
Yellow Tube (ACD)	_____ mls	_____ mls
Green Tube (Sodium Heparin)	_____ mls	_____ mls
Purple Tube (EDTA)	_____ mls	_____ mls

Regarding the donor designated above, I verify that the ABO type, degree of HLA match, compatibility testing results and infectious disease results are acceptable to proceed with MNC, Apheresis collection for above patient.

Form Completed By _____ Date (MM/DD/YYYY) _____ Ordering Physician _____