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| **RECIPIENT DETAILS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Recipient name |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| DOB day/month/year |  | | | | | | | | | | Sex | | | | | | | Male  Female | | | | | | | | | | | | | | | |
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| ID assigned by Anthony Nolan |  | | | | | | | | | | ID assigned by recipient’s TC | | | | | | |  | | | | | | | | | | | ID assigned by recipient’s Int registry | | |  | |
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| Diagnosis |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date of diagnosis | | |  | |
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| Has the patient previously received a stem cell transplant from an alternative donor or any other allogeneic cellular therapy (related or unrelated)? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | |
|  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| If yes, provide details | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Are any other donors in work up for this recipient? | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| If **yes**, is this donor the preferred donor? | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| Have any unrelated donors or cord blood units been identified? | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | | | | | | |
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| If yes, provide details | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Reason for asking Anthony Nolan to facilitate request: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **RELATED DONOR DETAILS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Donor name |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| GRID if known |  |  |  |  | |  | |  |  |  | |  |  |  |  |  |  | |  |  |  | |  |  |  |  |  |  | Donor ID if known | | |  | |
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| DOB\*\* day/month/year | 23/10/2020 | | | | | | | | | | Sex | | | | | | | Male  Female | | | | | | | | | | | Relationship to patient | | |  | |
| \*\* the donor must be a minimum age of 16 years old | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Mobile no |  | | | | | | | | | | | | | | | | | Alternative contact no | | | | | | | | | | |  | | | | |
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| Email |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Has the donor been informed that this request has been made? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | |
|  |  | | | | | | | | | |  | | | | | | |  | | | | | | | | | | |  | | |  | |
| Has the donor been educated on potentially becoming a stem cell donor? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | |
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| Is the donor able to understand spoken and written English? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | |
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| If no, please advise us of the donor’s first/preferred language? | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | |
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| **CONCURRENT VT / WUs** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you require donor VT blood samples to be drawn at medical for a **concurrent VT / WU**? \*\*  *If no, high-resolution typing reports should be sent with this request* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | |  | |
| \*\* If you have already requested VT samples via Anthony Nolan do not complete the below.   1. **For GIAS Transplant Centres: If yes, please leave the sample requirements/shipment details below blank and tick here**   **For International Registries: If the TC has ticked above to advise they are a GIAS Transplant Centre please send:**   * **2 x 4ml EDTA** * **1 x 4ml no anticoagulant**   **to the following address: Anthony Nolan Histocompatibility Laboratories, 77B Fleet Road, London NW3 2QU, UK**     1. **For non-GIAS TCs: If yes, please provide sample requirements and shipment details below** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
|  | ml EDTA | | | | | | | | | |  | | | | | | | ml ACD | | | | | | | | | | |  | | |  | |
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|  | ml Heparin | | | | | | | | | |  | | | | | | | ml no anticoagulant | | | | | | | | | | |  | | |  | |
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| **Samples to be delivered to:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Establishment name |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Name of individual completing form |  | Signature |  | Date day/month/year |  |

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| **IDENTIFICATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Recipient name | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ID assigned by Anthony Nolan | |  | | | | | | | | | | ID assigned by recipient’s TC | | | | | | | | | | |  | | | | | | | | ID assigned by recipient’s Int registry | |  |
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| Weight kg | |  | | | | | | | | | | ABO rh | | | | | | | | | | |  | | | | | | | | CMV status | |  |
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| **TRANSPLANT CENTRE** | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Establishment name | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **DONOR IDENTIFICATION** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Donor name | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| GRID | |  |  | |  | |  |  |  |  |  | |  | |  |  |  |  |  |  |  | | |  |  |  |  |  |  |  | Donor ID if known | |  |
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| Weight kg | |  | | | | | | | | | | ABO rh | | | | | | | | | | |  | | | | | | | | CMV status | |  |
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| **PRODUCT TYPE** |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| \* Please fill in a numerical value next to both products to indicate preference: 1 – 1st preference 2 – 2nd preference 0 – not wanted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Bone marrow (BM)** | |  | | | | | | | | | | | | | | | | | | | | | **PBSC** | | | | | | | |  | | |
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| Is this donor requested to consent to participate in an AN-approved clinical trial? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | No |
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| If yes, what is the name of the trial? | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
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| **PREFERRED DATES (in order of preference)** | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
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| For BM list preferred date of collection, for PBSC list preferred first date of collection | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Collection date: (day/month/year)** | | | | | | | | | | | | | | | | | | | | | | | **Corresponding infusion date: (day/month/year)** | | | | | | | | | | |
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| Minimum number of days clearance must be received prior to collection | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
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| Number of days recipient conditioning required prior to transplant | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
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| Date donor clearance is required by for first choice dates | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
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| Do you plan to cryopreserve the cells? | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | |
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| If yes, please tick reason one option only | | | | | | | | | | | | | | | | | | | | | | | Covid-19  Patient reasons  Donor reasons | | | | | | | | | Logistical reasons  Other | |
|  | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| Please provide a short explanation for selecting the above reason | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
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| **REQUIRED DOCUMENTATION: please include copies of recipient and donor high resolution tissue typing reports, and HLA typing form** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Name of individual completing form | |  | | | | | | | | | | Signature | | | | | | | | | | |  | | | | | | | | Date day/month/year | |  |

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| **IDENTIFICATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Recipient name | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ID assigned by Anthony Nolan | |  | | | | | | | | | ID assigned by recipient’s TC | | | | | | | | | | |  | | | | | | | | ID assigned by recipient’s Int registry |  |
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| Donor name | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| GRID | |  |  |  |  | |  |  |  |  | |  | |  |  |  |  |  |  |  | | |  |  |  |  |  |  |  | Donor ID |  |
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| **PRE-COLLECTION PERIPHERAL BLOOD SAMPLES** maximum 100 ml **Note**: This blood will be drawn at the donor’s medical unless otherwise requested | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | ml EDTA | | | | |  | | | | | | | ml ACD | | | | | | | | | Other samples  Please specify type/amount | | | | | | | |  | |
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|  | ml Heparin | | | | |  | | | | | | | ml no anticoagulant | | | | | | | | |  | | | | | | | |  | |
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| **Samples** to be delivered to | | | | | | | | | | | | | | | | | | | | | | **Product** to be delivered to | | | | | | | | | |
| Establishment name | |  | | | | | | | | | | | | | | | | | | | | Establishment name | | | | | | | |  | |
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| Address | |  | | | | | | | | | | | | | | | | | | | | Address | | | | | | | |  | |
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| Contact name | |  | | | | | | | | | | | | | | | | | | | | Contact name | | | | | | | |  | |
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| STIMULATED PBSC COLLECTION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| CD34+ cells per kg requested | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | x 10 ^6/kg | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | |
| x recipient weight (kg) | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | kg | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | |
| = total number of CD34+ cells | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | x 10 ^6 | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | |
| + CD34+ cells for quality testing | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | x 10 ^6 | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | |
| = total number of CD34+ cells for recipient | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | x 10 ^6 | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | |
| **Note i: If autologous plasma is not available for dilution HAS will be used;** | | | | | | | | | | | | | | | | | | | | | | **Note ii: Product will be transported cooled with ice packs** | | | | | | | | | |
| For Anthony Nolan donors: we will aim for a CD34+ cell count of **4 x 10^6/kg**. A brief explanation is required if a count of **6 or higher** is requested: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **CELL DILUTION         Cells must be diluted with plasma to a final TNC concentration of <200 x 10^6/ml** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| |  |  | | --- | --- | | **Comments:** | 1. **Aim for a haemocrit level of less than 4%** 2. **Leave a 10-20cm bleed line on each bag for sterile clamping & docking** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Any additional comments:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **PERIPHERAL BLOOD SAMPLES TO BE COLLECTED AT FIRST APHERESIS** maximum 100 ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | ml EDTA | | | | |  | | | | | | | ml ACD | | | | | | | | | Other samples  Please specify type/amount | | | | | | | |  | |
|  |  | | | | |  | | | | | | |  | | | | | | | | |  | | | | | | | |  | |
|  | ml Heparin | | | | |  | | | | | | | ml no anticoagulant | | | | | | | | | Additional plasma Please specify amount in ml | | | | | | | |  | |
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| Clinical prescriber completing form | |  | | | | | | | | | Signature | | | | | | | | | |  | | | | | | | | | Date day/month/year |  |
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| **IDENTIFICATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Recipient name | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ID assigned by Anthony Nolan | |  | | | | | | | | | ID assigned by recipient’s TC | | | | | | | | | | |  | | | | | | | | ID assigned by recipient’s Int registry |  |
|  | |  | | | | | | | | |  | | | | | | | | | | |  | | | | | | | |  |  |
| Donor name | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| GRID | |  |  |  |  | |  |  |  |  | |  | |  |  |  |  |  |  |  | | |  |  |  |  |  |  |  | Donor ID |  |
|  | |  | | | | | | | | |  | | | | | | | | | | |  | | | | | | | |  |  |
| **PRE-COLLECTION PERIPHERAL BLOOD SAMPLES** maximum 100 ml **Note**: This blood will be drawn at the donor’s medical unless otherwise requested | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | ml EDTA | | | | |  | | | | | | | ml ACD | | | | | | | | | Other samples  Please specify type/amount | | | | | | | |  | |
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|  | ml Heparin | | | | |  | | | | | | | ml no anticoagulant | | | | | | | | |  | | | | | | | |  | |
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| **Samples** to be delivered to | | | | | | | | | | | | | | | | | | | | | | **Product** to be delivered to | | | | | | | | | |
| Establishment name | |  | | | | | | | | | | | | | | | | | | | | Establishment name | | | | | | | |  | |
|  | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | |
| Address | |  | | | | | | | | | | | | | | | | | | | | Address | | | | | | | |  | |
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| Contact name | |  | | | | | | | | | | | | | | | | | | | | Contact name | | | | | | | |  | |
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| Phone number | |  | | | | | | | | | | | | | | | | | | | | Phone number | | | | | | | |  | |
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| Out of hours number | |  | | | | | | | | | | | | | | | | | | | | Out of hours number | | | | | | | |  | |
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| Email | |  | | | | | | | | | | | | | | | | | | | | Email | | | | | | | |  | |
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| Note: Please fax collection report to DonorProvision@anthonynolan.org | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BONE MARROW COLLECTION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nucleated cells per kg requested | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | x 10 ^8/kg | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | |
| x recipient weight kg | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | kg | |
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| = total number of nucleated cells | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | x 10 ^8 | |
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| + nucleated cells for quality testing | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | x 10 ^8 | |
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| = total number of nucleated cells for recipient | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | x 10 ^8 | |
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| Anticoagulant | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
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| Transport temperature | | | | | | | | | | | Cooled with ice packs | | | | | | | | | | | | | | | | | | | Room Temperature | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Additional comments | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
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| **PERIPHERAL BLOOD SAMPLES TO BE COLLECTED AT TIME OF COLLECTION** maximum 100 ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | ml EDTA | | | | |  | | | | | | | ml ACD | | | | | | | | | Other samples  Please specify type/amount | | | | | | | |  | |
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|  | ml Heparin | | | | |  | | | | | | | ml no anticoagulant | | | | | | | | |  | | | | | | | |  | |
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| Clinical prescriber completing form | |  | | | | | | | | | Signature | | | | | | | | | |  | | | | | | | | | Date day/month/year |  |