CELLULAR THERAPY CENTRE	# REQUEST OF BLOOD CELL OR BONE MARROW PRODUCTS	
Feodor-Lynen-Str. 21 30625 Hannover, DE	PLEASE SEND TO CTC AT LEAST 2 WORKING DAYS IN ADVANCE VIA **FAX 0049 511 532 7977**	Phone: 0049 511 532 7960 **24h:** 0049 176 1532 5826

REQUEST OBJECTIVE

☐ **Information** about products

☐ Reconstitution of products

☐ Product **delivery** (DDMMYYYY HH:MM): ____________ **Site:** ______________ **Transport** by: ☐ CTC-courier ☐ Ordering site

REQUESTED BY:

Physician (responsible): ______________________________
legible surname

Clinic/Department/Practice: ______________________________

Phone /Fax/Pager: ______________________________

PRODUCT TYPE

☐ blood stem cells ☐ donor lymphocytes ☐ bone marrow

REQUIRED LOT/BAGS (only when delivery required)

☐ **all** available products of lot/s: ☐ **only** products with lot designation/s:

______________ please enter lot No. ______________ please enter lot No. ______________ please enter lot No. ______________ bitte Charge eintragen

CORRESPONDING CELLS/KG BW: ____________ ×10 —— **CELL TYPE:** ____________

PRODUCT DELIVERY AS:

☐ cryopreserved product ☐ fresh/reconstituted product ☐ other: ____________

☐ **autologous donor/patient** ☐ **family donor** ☐ **register (unrelated) donor**

RECIPIENT/PATIENT	**DONOR**
______________________________ surname, name and/or patient ID	______________________________ surname, name and/or donor ID/GRID
____________ date of birth (DD.MM.YYYY) ____________ Station	____________ date of birth (DD.MM.YYYY)
Diagnosis: ______________________	
Body weight: ________ **kg** (actual body weight) **Blood type:** ________ (AB0, Rh)	**Body weight:** ________ **kg** (when known) **Blood type:** ________ (AB0, Rh)

I have read and taken note of the CTC information on data protection at https://www.mhh.de/en/institutes-and-central-research-institutions/translate-to-englisch-institut-fuer-zelltherapeutika/translate-to-englisch-cellular-therapy-centre-ctc/data-protection

Remark: ______________________________

Date: ______________ **Signature:** ______________

TO BE COMPLETES AND SEND (FAX) BACK BY CTC:

☐ Request reviewed (QP or head of QC) Date:........................ Signature:..............................

☐ Requested products available/comply Date:........................ Signature:..............................

☐ Delivery prepared (entered in delivery calendar) Date:........................ Signature:..............................