CELLULAR THERAPY CENTRE Feodor-Lynen-Str. 21 30625 Hannover	**PRESCRIPTION/ORDER** FOR THE COLLECTION/HARVEST AND/OR PROCESSING OF BLOOD CELL OR BONE MARROW PRODUCTS SEND AT SCHEDULING OF COLLECTION/HARVEST TO CTC VIA FAX: **0049 511 532 7977**	Page 1 of 1 Phone: 0049 511 532 7960 **24h:** 0049 176 1532 5826

REQUESTED PRODUCT TYPE

☐ blood stem cells (apheresis) ☐ donor lymphocytes (apheresis) ☐ donor lymphocytes (blood) ☐ bone marrow

PRODUCT COLLECTION/HARVEST: ☐ Transfusion Medicine MHH ☐ external (if known) _____

In case that the collection of blood stem cells or donor lymphocytes is to be performed at the **Institute for Transfusion Medicine and Transplant Engineering** MHH, CTC will forward this binding order immediately to this collection site

DATE OF COLLECTION/HARVEST – APHERESIS, BLOOD, BONE MARROW: _____

PRODUCT SHIPPED BY: ☐ CTC-Courier ☐ Prescriber's courier: _____

ORDER/REQUIRED PROCESSING (MULTIPLE CHOICE POSSIBLE

☐ **only** quality control (e.g. CD34/CD3 counts)o ☐ fresh product ☐ cryopreservation

☐ CD34-selection ☐ TCRαβ/CD19-depletion ☐ CD3/CD19-depletion ☐ CD45RA-depletion

☐ plasma reduction ☐ erythrocyte reduction ☐ other: _____

ORDERED BY

Physician (responsible)**:** _____
legible surname

Clinic/Department/Practice: _____

Phone /Fax/Pager: _____

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

RECIPIENT/PATIENT

_____
surname, name and/or patient ID

_____ _____
date of birth (DD.MM.YYYY) Station

Diagnosis: _____

Body weight: _____ **kg** **Blood type:** _____
actual body weight AB0, Rh

DONOR

_____
surname, name and/or donor ID/GRID

_____
date of birth (DD.MM.YYYY)

Body weight: _____ **kg** **Blood type:** _____
when known AB0, Rh

Donor infection disease marker: ☐ **negative** (HBV/HCV/HIV/HEV/Lues) known **positive**: ☐ **HBV** ☐ **HCV** ☐ **HIV** ☐ **HEV** ☐ **Lues**

Please provide result of testing within 30 days prior collection/harvest to CTC via fax!

Required cell type (e.g. CD34, T-cells etc.)**:** _____ **Number of re-/transplantations planned:** _____

Required cell numbers (per infusion/kg BW)**:** _____ **×10 — /kg**

Only T-cell aliquots (per infusion/kg BW)**:** **fresh** ___ **×10 —** **cryo** ____ **×10 —** ____ **×10 —** ____ **×10 —** ____ **×10 —**

Scheduled delivery time (DD.MM.YYYY HH:MM)**:** _____ **Site:** _____ **Delivery of final product by:** ☐ CTC-Courier ☐ Prescriber's courier

Remark: _____

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

Date: _____ **Signature:** _____