INLAND NORTHWEST BLOOD CENTER
210 W. Cataldo Ave., Spokane WA 99201

# HEMATOPOIETIC PROGENITOR CELL REQUEST

**Physician** _____ Telephone _____ Fax _____

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

Former Last Name(s)_____

DOB _____ Telephone _____ Mobile:_____

Hemoglobinopathy Risk: ❑ Yes ❑ No Height _____ Weight _____

Diagnosis:_____ Collection Goal _____ x $10^6$ CD34+ cells/kg

Vascular Access Type: _____ 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 _____

Mozabil: ❑ Yes ❑ No If Yes, Date to be administered: _____

*Pre Mozabil* CD-34 count to be sent the day prior to collection: ❑ Yes ❑ No

*If Yes*, To: INBC or Other: _____ **NOTE: CD-34 count is not required to qualify patient when Mozabil is administered for next day collection**

**CD34 Samples to be Drawn Starting:** _____
(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.***