STEM CELL LABORATORY (STCL)

DOCUMENT NUMBER: STCL-FORM-060

DOCUMENT TITLE:

Inter-institutional Physician's Agreement Request to Transfer Patient Product

DOCUMENT NOTES:

Document Information

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Author: WATE02	**Owner:** WATE02
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Duke University Medical Center
Stem Cell Laboratory
2400 Pratt Street, Suite 1300
Durham, North Carolina 27705

Inter-institutional Physician's Agreement
Request to Transfer Patient Product

Date: _____

Dr. _____ MD has requested that the _____ (product type) which was collected from **Patient Name (DOB)** at Duke University Medical Center and processed by the Stem Cell Laboratory on _____ be shipped to _____ (facility name) on _____(date) for delivery to the following location on _____ (delivery date):

Attention:
Name
Facility Name
Physical Address
Town, State Zip Code
E-mail: contact person's e-mail address

The final, processed product contains ~ _____ x 10e9 total nucleated cells, ~_____ x 10e8 cells/kg (based on the recipient's weight of _____ kgs at the time of collection, and ~ _____ x 10e6 CD34+ cells/kg. Written authorization is required from Dr. _____ (or designee) from _____ (transplant center name), Mr. or Ms. _____, and Dr. _____MD before cells can be shipped from Duke. Once the product has been shipped to_____ (transplant center name), Duke University Medical Center will no longer be held responsible for these cellular products. Copies of the source documentation associated with the processing, testing, and cryopreservation of this cellular product will be provided by the Stem Cell Laboratory at Duke University Medical Center along with the product at the time of shipment. A validated, charged dry shipper will be provided but shipping fee (to and from your facility) will need to be covered by your institution. Cells will be placed in the dry shipper and transported from Duke to _____ (transplant center name). Upon arrival, the cells should be relocated to a designated LN2 freezer (-150 C or colder) until such time that the product is thawed for administration to the recipient.

Once all parties have signed the form ,where indicated below, please return to Barbara Waters-Pick via fax # 919-684-1555 (phone 919-668-1178) so the final details of this transfer can be arranged.

Physician's signature: _____, MD

(Dr. _____ MD, Facility Name, Town, State)

Patient's signature: _____

(Mr. or Ms. _____)

Physician's signature: _____, MD

(Dr. _____ MD, Duke University Med Ctr, Durham, NC)

Signature Manifest

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All dates and times are in Eastern Time.

STCL-FORM-060 Inter-institutional Physician's Agreement Request to Transfer Patient Product

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Document Release

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