STEM CELL LABORATORY (STCL)

DOCUMENT NUMBER: STCL-COLL-007 FRM1

DOCUMENT TITLE:

Autologous and Directed Collection and Processing Order Form

DOCUMENT NOTES:

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Control Information

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Stem Cell Laboratory

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Auto/Directed Collection and Processing Order Form

Anticipated Due Date: _____

Description of Product (check appropriate items)

_____ Autologous Cord Blood (UCB) _____ Directed Cord Blood (UCB)

Donor Identification:

Full name of mother:_____ Phone number: _____

Address:_____ Date of birth:_____

_____ Mother's SS# _____

Mother's email address:_____

Recipient Identification:

(affix addressograph label if available)

Recipient's Name: _____ Recipient's Medical Record #: _____

Recipient's DOB: _____ Recipient's ABO/Rh: _____

Recipient's Diagnosis: _____

Processing needed: Process directed/autologous umbilical cord blood as per SOPs to include: cell counts and differential (pre- and post- processing), viability, HPC assays, flow cytometry, and bacterial cultures (pre- and post-processing).

Cryopreservation Needed: (Yes/No?) _____ Backup: _____

Billing: Self Pay _____ No Charge _____ Insurance _____

Insurance Company name:_____ Telephone number:_____

Address: _____ Group number: _____

_____ SSN of Policy Holder: _____

Name of policy holder: _____ Date of birth of policy holder_____

Policy number: _____

I request that the umbilical cord blood be collected by designated personnel and then processed as outlined above.

Requesting Physician/Pager #: _____ Date: ___/___/___

Signature

COMMENTS: (Specifiy add'l testing, typing, etc) _____

_____

_____

Kit and Contract sent by: _____ Date: ___/___/___

Date Signed contract returned:_____ Date Unit received:_____

Date Unit banked:_____ Date Billed (if applicable):_____

Field	Requirements
Anticipated Due date	Enter date obtain from mother as when baby is due.
Description of Product	Check if collection will be auto or directed.
Donor Identification	Enter name, phone number, address, date of birth, name of obstetrician and social security number of mother.
Recipient Identification	Enter the name, history number, date of birth and ABO Rh of recipient if known.
Billing	Check appropriate billing information
Insurance information	Enter donor's insurance information i.e. name of company, address, phone number, policy #, group number, policy holder's SS#, policy holder's date of birth and name of policy holder.
Requesting Physician/pager number	Have requesting physician sign order form.
Kit and contract sent by	Enter the name of the person who sent the kit/contract
Date Unit Received	Enter the date unit received
Date Unit banked	Enter the date unit was processed and banked
Date Billed (if applicable)	Enter date billed (if applicable) or NA.

Signature Manifest

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All dates and times are in Eastern Time.

STCL-COLL-007 FRM1 Auto/Directed Collection and Processing Order Form

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Document Release

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