Patient Name ________________________________ Patient DOB ____ / ____ / ______

Patient Weight ____________ lbs.

Absolute Neutrophil Count ____

Underlying disease leading to neutropenia ____

Patient Blood Type _________ Patient CMV Status _________

Anticipated days of therapy _________

Starting on (date) ______ / ______ / _________

Note: donor recruitment, stimulation and product prep require ≈ 24 hours)

Ordering Physician ____

Ordering Physician Phone ( ) - ________ - ____________

Transfusing Facility ____

Infectious indication for granulocyte transfusion (check those applicable)

- ☐ Culture – documented bacterial infection not responding to active antimicrobials
- ☐ Culture – documented fungal infection not responding to active antimicrobials
- ☐ Persistent febrile neutropenia, unresponsive to empiric antimicrobials
- ☐ Other (explain) ____

I understand that:

1. The clinical situation is urgent and donor infectious disease testing (e.g. HIV, HBV, HCV and others) for this granulocyte donor may not be complete at the time of transfusion. I agree that the benefit of transfusing this product outweighs this risk.
2. The product can only be used for this specific patient.
3. I will provide testing results for CMV as soon as possible
4. The donor will undergo stimulation with G-CSF(Granulocyte Colony Stimulating Factor) and dexamethasone prior to the collection.
5. The charges will not be cancelled once the donor is stimulated.
6. In the event this product is not needed that I will contact the Blood Center immediately. Call 800-747-5401 and ask for “apheresis on call”

Requesting Physician ________________________________ Date ____ / ____ / ______

MVRBC Physician ________________________________ Date ____ / ____ / ______

Blood Center 24 Hour Contact Number: 563-349-1677

Blood Center Fax Number: 563-823-8941