**This HCT form should only be used for autologous back up.**

Sequence number:

Date Received: \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_ (DD-MMM-YYYY)

Center Number:

Recipient ID:

Date of HCT for which this form is being completed: \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_

(DD-MMM-YYYY)

HCT Type (check only one):

Autologous (back up infusion)  Gene therapy (vector) product  Gene editing product

Product Type (check only one):

Bone marrow  PBSC

**Pre-Collection Therapy**

1. Did the patient receive therapy, prior to any stem cell harvest, to enhance the product collection for this HCT?

Yes  No

1. Growth and mobilizing factor(s)

Yes  No

1. Plerixafor (Mozobil):

Yes  No

1. Other growth or mobilizing factor:

Yes  No

1. Specify other growth or mobilizing factor:
2. Systemic reporting therapy (chemotherapy):

Yes  No

1. Other therapy:

Yes  No

* 1. Specify other therapy:

**Product Collection**

1. Date of first collection for this mobilization: \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_ (DD-MMM-YYYY)
2. Was there more than one collection required for this HCT?

Yes  No

1. Specify the number of subsequent days of collection in this episode: \_\_\_\_\_\_\_\_\_\_\_\_\_
2. Were anticoagulants added to the product during collection?

**Specify anticoagulant(s):**

1. Acid citrate dextrose (ACD)

Yes  No

1. Citrate phosphate dextrose (CPD)

Yes  No

1. Heparin

Yes  No

1. Other anticoagulant

Yes  No

* 1. Specify other anticoagulant:

1. Were anticoagulants added to the product before freezing?

Yes  No

**Product Infusion (unmanipulated autologous product)**

1. Date of this product infusion: \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_ (DD-MMM-YYYY)
2. Date Infusion started: \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_ (DD-MMM-YYYY)
3. Time product infusion initiated (24-hourclock): \_\_\_\_\_\_\_\_\_\_\_\_ \_

Standard time  Daylight savings time

1. Date infusion stopped: \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_ (DD-MMM-YYYY)
2. Time product infusion completed (24-hour clock): \_\_\_ \_\_\_

Standard time  Daylight savings time

1. Total volume of product plus additives intended for infusion: \_\_\_\_mL
2. Specify the route of product infusion

Intravenous  Other route of infusion