**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