SEATTLE CHILDREN'S THERAPEUTICS THERAPEUTIC CELL PRODUCTION CORE COMMUNICATION FORM	Document number: CF-02488-03 Revision: 02 Effective date: 01/11/2023
PLAT-07	

MNC COLLECTION FORM: SCRI-CAR22v2

PATIENT INFORMATION

LAST NAME _____ **FIRST NAME** _____ **MIDDLE NAME** _____

DATE OF BIRTH

_____/ _____/ _____
(MM) (DD) (YYYY)

RECIPIENT MRN or IDENTIFIER: _____ **SUBJECT ID:** 02488-S_____

MNC COLLECTION INFORMATION

Collection Center Name:

_____

Date of Collection: _____/_____/_____ (MM) (DD) (YYYY)

Collection End Time: _____

Whole Blood Volume Processed: _____mL

Collection Volume + Anticoagulant: _____mL × 0.3 = ≥ _____mL

Minimum Target Plasma Volume:

Date and Time Product Packaged for Transport: _____

MNC COLLECTION SUMMARY

Plasma volume added to MNC Collection bag is at least 30% of Collection Volume + Anticoagulant	☐ PASS ☐ FAIL
Total MNC product volume does NOT exceed 600mL	☐ PASS ☐ FAIL
MNC Bag Label affixed to collection bag and all patient identifiers are legible and have been verified	☐ PASS ☐ FAIL
Proximal seals to the collection bag are hermetic (only heat seals and metal clips are acceptable)	☐ PASS ☐ FAIL
Anticoagulant was used	☐ PASS ☐ FAIL

COMMENTS	ID Label
☐ N/A	Place Hospital ID Label Here

OPERATOR INFORMATION

Completed By: _____ **Date:** _____

E-MAIL COMPLETED FORM TO TCPC@seattlechildrens.org.

FILE COMPLETED FORM IN CLINICAL SUBJECT STUDY BINDER