Autologous HCT/P Requisition Form

DREGALLA MEDICAL TECHNOLOGIES
2627 Redwing Rd., Ste. 230
Ft. Collins, CO 80526
rdregalla@DreMedTech.com
720.201.2666

Demographic Information

Study ID (if applicable): _____ Collection Date: _____
MM DD YYYY

Physician Name: _____ Patient ID: (do not use name) _____

Patient DOB: _____
MM DD YYYY

Autologous Human Cell/Tissue Product Type (use "NA" or leave blank as needed)

Bone Marrow	**BMA**	**BMC**	Order Request/Notes:
Total Volume (e.g.,60mL BMA/6mL BMC)	_____	_____	☐ TNC ☐ VIA ☐ CFU-f ☐ PLT ☐ RBC ☐ WBC Dist. ☐ Other:
Volume Shipped (BMA/BMC req. >0.25c.c.)	_____	_____	
Anticoagulant Type	☐ Heparin	☐ ACD-A	Other:

Adipose	**Lipoaspirate**	**Micro-Fat**	Order Request/Notes:
Total Volume (e.g.,40mL LA/5mL MFAT)	_____	_____	☐ TNC ☐ VIA ☐ CFU-f ☐ Other:
Volume Shipped (LA/MFAT req. >0.5c.c.)	_____	_____	

Peripheral Blood	**WB**	**PRP**	Order Request/Notes:
Total Volume (e.g.,50mL WB/4mL PRP)	_____	_____	☐ PLT ☐ VIA ☐ RBC ☐ WBC Dist. ☐ Other:
Volume Shipped (LA/MFAT req. >0.5c.c.)	_____	_____	
Anticoagulant Type	☐ Heparin	☐ ACD-A	Other:

For DreMedTech Use Only

Date Received _____ Date Completed _____
MM DD YYYY MM DD YYYY

Time Received _____ Time Completed _____

Initials _____ Initials _____

TNC - total nucleated cell count; VIA - viability; CFU-f - colony forming units-fibroblast; RBC - red blood cell; WBC Dist. - white blood cell distribution