

STEMCYTE, Inc.

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Print completed form and
FAX to: **Robert Chow**
Fax: (626) 430-9043

CBU-Specific Request Form

Date of Request:

Reference Patient/s:

| CB Unit ID | Cord Blood Unit Report | Samples For Confirmatory Typing | | Other |
|----------------------|--------------------------|--|---------------------------------------|--------------------------------|
| <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> DNA <input type="checkbox"/> Whole Blood <input type="checkbox"/> _____ | Ship Unit <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Patient | | Note: _____ | Reserve Unit <input type="checkbox"/> | |
| <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> DNA <input type="checkbox"/> Whole Blood <input type="checkbox"/> _____ | Ship Unit <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Patient | | Note: _____ | Unit <input type="checkbox"/> | |
| <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> DNA <input type="checkbox"/> Whole Blood <input type="checkbox"/> _____ | Ship Unit <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Patient | | Note: _____ | Reserve Unit <input type="checkbox"/> | |

Requestor Information:

NAME:

Facility:

Address:

Telephone Number:

FAX Number:

eMail Address:

Shipping Information:

NAME:

Facility:

Address:

Telephone Number:

FAX Number:

Special Instructions / Pricing:

FOR StemCyte USE

Received: By _____ Date: _____ Routed To: _____

Action: _____ By _____ Date: _____