BLUTSPENDE SRK SCHWEIZ
TRANSFUSION CRS SUISSE
TRASFUSIONE CRS SVIZZERA
SWISS BLOOD STEM CELLS

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TRANSPLANT REQUEST

Patient Data

Name First Name Date of birth (dd/mm/yyyy)

Donor selection

GRID / CBU:

Date of birth (dd/mm/yyyy)

Timeframe of transplantation (dd/mm/yyyy)

Transplant Center

Center Name **Universitätsspital Basel**

Transplant physician

The transplant physician confirms that the valid cost guarantee for this request is available.

Date Signature transplant physician