



# STEM CELL PROCESSING FORM

Please print throughout this form.

Horse's Name \_\_\_\_\_  
Sex \_\_\_\_\_  
Age \_\_\_\_\_  
Breed \_\_\_\_\_

**SAMPLE COLLECTION**  
Date Collected \_\_\_\_\_  
Time Collected \_\_\_\_\_  
Site of Collection \_\_\_\_\_  
Heparin Concentration \_\_\_\_\_  
Total Aspirate Volume \_\_\_\_\_

Diagnosis: \_\_\_\_\_  
Location: LF RF LR RR Other \_\_\_\_\_  
Duration of Injury: Acute Chronic Onset of Injury? \_\_\_\_\_  
Severity of Injury: Mild Moderate Severe  
Cells will be used with surgery: Yes No Type of surgery: \_\_\_\_\_

## PROTOCOL

**Please contact the Rood & Riddle Stem Cell Laboratory prior to shipping your bone marrow sample.**  
**Stem Cell Expansion and Treatment Protocol**

Treatment Dosage (millions per treatment): 10 20 30 40 Other  
Number of Treatments: 1 2 3 4 Other  
Treatment Cycle (in weeks): 2 4 8 12 Other

## Expansion and Banking for Future Use

A total of four, 15 million-cell doses will be obtained for treatment and long term storage. The first year of storage is included in any stem cell expansion order. Owners will be billed \$175 per year unless notified.

## HORSE OWNER INFORMATION

Horse Owner(s) \_\_\_\_\_  
Farm/Ranch Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work/Cell Phone \_\_\_\_\_  
Email \_\_\_\_\_

## ATTENDING VETERINARIAN

Name of Veterinarian \_\_\_\_\_  
Veterinary Practice \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone Number \_\_\_\_\_  
Fax Number \_\_\_\_\_  
Email \_\_\_\_\_

## BILLING INFORMATION:

**Veterinarians will be billed for Bone Marrow culture and expansion costs**

Bill Credit Card on File  Bill Credit Card Listed Below  Check Enclosed

IF PAYING BY CREDIT CARD, FILL OUT THE INFORMATION BELOW:

Card Type:  Visa  MasterCard  American Express  Discover

Card Holder's Name (as it appears on card): \_\_\_\_\_

Card Number \_\_\_\_\_ Expiration Date (month/year) \_\_\_\_\_

Card Verification Code \_\_\_\_\_ Signature \_\_\_\_\_

BILLING ADDRESS (IF DIFFERENT FROM ABOVE)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_