STEM CELL SUBMISSION FORM - LARGE ANIMAL

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Animal and Contact Information

Veterinarian:	**Organization:**
Telephone:	**Email:**
Owner Name:	**Owner consent submitted:** ☐ **Yes** ☐ **No**
AnimalName:	**Sport/Discipline:**
Species:	**Breed:**
Date of Birth/ Age:	**Sex:** ☐ **Male** ☐ **Female**
Neutered? ☐ **Yes** ☐ **No**	**Body Score: (1=Thin,10=Fat):**
Fat Collection Date and Time:	**Number of Collection Tubes Submitted:**

Injury Information

Injury Date or Duration of disease:	LastResort? ☐ Yes ☐ No
☐ **New Injury** ☐ **Re-injury** ☐ **Chronic**	**Location:**

Tendons & Ligaments:

Number of lesions to be treated:	
☐ SDFT ☐ DDFT ☐ Extens ☐ Check ☐ Colat ☐ SL Branch ☐ SL Body ☐ SL Origin ☐ Impar ☐ Other: _____	
Complications: ☐ Avulsion ☐ Sepsis ☐ Sheath	Size/Severity: ☐ Small ☐ Medium ☐ Large/Severe
Description/Zones:	
Previous Treatments:	

Joints:

Number of sites to be treated	Severity: ☐ Mild ☐ Moderate ☐ Severe
Injury Type: ☐ OA ☐ OCD – No Cyst ☐ OCD with Cyst ☐ Meniscus ☐ Cartilage ☐ Other:_____	
Description (affected joints):	Cells to be used with surgery? ☐ Yes ☐ No
Previous Treatments:	

Fractures and Other Indications:

Number of sites to be treated:	Injury Type: ☐ Avulsion ☐ Plated Fracture ☐ Other:____
Description and Location:	

(Please contact MBG-Stem veterinarian to discuss treatment options)

Syringe&OrderSpecifications(Onedose =one syringe = one lesion or site to betreated)

- Standard forintra-articular/intralesional administration: 2.0 mL per syringe (recommended)
- Standard for IV administration: 5 mLsyringe with a Hemo-Nate filter

Treatment Plan: Indicate the number of syringes per volume requested for the initial treatment. Processing occasionally does not yield sufficient cells for fulfilment of the preferred treatment plan. Please provide an alternate treatment plan based on highest priority treatment sites and methods:

☐ @0.6mL Volume ☐ @2mL ☐ @5mL w/Hemo-Nate (forIVonly) ☐ Other: _____

Delivery instructions for initialtreatmentand Banking

☐ ***Standard Service*** = Deliver syringes for initial treatment and bank additional doses if cell yield permits

☐ Ship All Cells Back ☐ Other: _____

Ship overnight only. PleaseUseMBG-StemprovidedCollectionKitandColdPack.

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