

REQUEST FOR DONOR LYMPHOCYTE REINFUSION



Registration No. 2000/026390/08

To be completed by Clinical Unit:

Donor		Recipient	
Title		Title	
Name and Surname		Name and Surname	
DOB/ID		DOB/ID	
Gender		Gender	
Height		Height	
Weight		Weight	
Hospital		Hospital	
Hospital number		Hospital number	
Blood Group		Blood Group	
Physician		Physician	
Contact Details		Contact Details	
		Patient diagnosis	
		Current disease status	

To be completed by Clinical Unit:

Procedure	Issue to transplant Centre ☐ Thaw at the bedside ☐ Transfer elsewhere ☐		
CD3 dose required (if known)		Location required	
Date required		Time required	

Product Information:

To be completed by CTL					Clinical Facility
Unit number	Collection date	CD3 dose	CD3 viability	Sterility	Tick products to be released
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

I have medically examined the patient and I consider that the patient will tolerate the re-infusion without any significant untoward reaction.
I understand that the staff of SANBS will assist with re-infusion. I have made arrangements for emergency medical care should this be necessary. I understand that I am medically responsible for the patient and will be available for consultation, or in the event of any untoward reaction.

NOTE: The infusion should be carried out by medical practitioner or registers nurse and be assisted by the Cellular Therapy Medical Technologist, registered nurse from SANBS or from the hospital. The attending physician / haematologist or his/her nominated medical practitioner must be available at all times during the infusion.

Name and Surname..... Signature..... Date.....

SANBS Use only		
Bags confirmed as available and OK to use	☐ YES	☐ NO
Completed by:		
Name and Surname.....	Signature.....	Date.....
Verified by:		
Name and Surname.....	Signature.....	Date.....