REQUEST FOR CELLULAR THERAPY PRODUCT REINFUSION

Registration No. 2000/026390/08

Patient safety: The availability of cryopreserved products must be confirmed in writing between the Cellular Therapy Laboratory (CTL) and the referring Clinical Facility before the patient commences conditioning therapy. Please send the completed form at least **4 – 6 working days before the commencement of conditioning therapy to the Cellular Therapy Laboratory:**

A. To be completed by Clinical Unit/requesting doctor:

Donor		**Recipient (Allogeneic donors only)**	
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	
Product type	Autologous ☐ Allogeneic ☐		
Procedure	Issue to transplant Centre ☐ Thaw at the bedside ☐		
Location required		Date required	Time required

Completed by requesting doctor:

Name and Surname ----------

Signature ----------Date ----------

B. To be completed by CTL:

Post Thaw Viability (%)				
Harvest 1:	CD45		CD34	
Harvest 2:	CD45		CD34	
Harvest 3:	CD45		CD34	
Harvest 4:	CD45		CD34	
Comments:				

C. To be completed by CTL and the clinical facility:

Product Information (to be completed by CTL)								Clinical Facility
Unit number	**Collection date**	**Total Harvest CD34 (x10⁶/kg)**	**Total Number of Aliquots**	**Volume of Bag**	**Bag CD34 (x10⁶/kg)**	**Bag viable CD34 (x10⁶/kg)**	**Sterility**	**Tick products to be released**
								☐ Yes ☐ No
								☐ Yes ☐ No
								☐ Yes ☐ No
								☐ Yes ☐ No
								☐ Yes ☐ No
								☐ Yes ☐ No
								☐ Yes ☐ No
								☐ Yes No

D. Completed by requesting doctor:

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 a medical practitioner or registered 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 re-infusion.

Requesting Doctor

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

SANBS Use only:

Bag confirmed as available and OK for use □Yes □No

Completed by:

Name and Surname: ……..Signature ……Date …….

Verified by:

Name and Surname: ……..Signature ……..Date …….