

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 referring Clinical Facility before the patient commences conditioning therapy. Please send the completed form at least **4 – 6 working days before commencement of conditioning therapy to 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 <input type="checkbox"/> Allogeneic <input type="checkbox"/>		
Procedure	Issue to transplant Centre <input type="checkbox"/> Thaw at the bedside <input type="checkbox"/>		
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 Clinical Facility/requesting doctor:

Product Information (to be completed by CTL)							Clinical Facility
Unit number	Collection date	Total Harvest CD34 (x10 ⁶ /kg)	Total Number of Aliquots	Bag CD34 (x10 ⁶ /kg)	Bag viable CD34 (x10 ⁶ /kg)	Sterility	Tick products to be released
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No

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 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.

Requesting Doctor

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

SANBS use only:	
Bags confirmed as available and OK to use	YES <input type="checkbox"/> / NO <input type="checkbox"/>
Completed by:	
Name and Surname-----	Signature-----Date-----
Verified by:	
Name and Surname -----	Signature-----Date-----