STEM CELL LABORATORY (STCL)

DOCUMENT NUMBER: STCL-FORM-056

DOCUMENT TITLE:

Cellular Therapy Infusion Request Form

DOCUMENT NOTES:

Document Information

Revision: 07	**Vault:** STCL-Form-rel
Status: Release	**Document Type:** STCL FORM

Date Information

Creation Date: 02 Oct 2019	**Release Date:** 21 Oct 2019
Effective Date: 21 Oct 2019	**Expiration Date:**

Control Information

Author: WATE02	**Owner:** WATE02
Previous Number: STCL-PROC-029 Rev 06	**Change Number:** STCL-CCR-469

Cellular Therapy Infusion Request Form

Infusion Date:____/_____/_____

Attention: Nursing Staff
Place EPIC Patient
Label Here

PATIENT IDENTIFICATION: LABEL FROM STCL

****

HEMATOPOIETIC or CELLULAR THERAPY PRODUCT

(***CHECK ONE***) □ AUTOLOGOUS □ ALLOGENEIC □ SYNGENEIC

(***CHECK ONE***) □ HPC, Cord Blood □ HPC, Apheresis □ HPC, Marrow □ MNC, Apheresis □ Other _____

Reinfusion Barcode #:_____ Description of Product: _____

Collection Date: _____/_____/_____ Expiration Date: _____

Bags:_____ Total Volume _____ml

Total Nucleated Cell Count (TNCC):_____(*not corrected for viability*)

Total Cell Dose: _____x10^8 / kg

CFU-GM Dose: _____x10^4 / kg *(if available)*

CFU-GEMM Dose: _____x10^4 / kg *(if available)*

CFU-BFUE Dose: _____x10^4 / kg *(if available)*

Total CD34+ Dose (***fresh***): _____x10^6 / kg *(if available)*

Total CD34+ Dose (***pre-freeze***): _____x10^6 / kg (*if available*)

****

I request that the hematopoietic progenitor cell or other cellular product, as described above, be released, thawed *(if applicable),* and infused into the above identified recipient.

Thawing and Infusion as per Protocol #: _____ (*if applicable*)

(***Check ONE***) Single Transplant _____Tandem Transplant _____Tissue Transplant _____

Requesting Physician_____ ID#_____ Date: _____

Special Instructions: _____

_____

_____

_____

BACK UP:_____

Viability (%):_____ Total Viable Nucleated Cell Count (TNCC):_____

Percent recovery post thaw and/or manipulation _____ (%)

NOTE: If viability is <70% and/or % recovery (not corrected for viability) is <70% (for UCB) or <85% (for PSC or BM), post thaw or manipulation, notify medical director and/ or designee, immediately.

****

Date:_____ Time(EST):_____ Delivery Person's Signature: _____

Date:_____ Time(EST):_____ Receipt Person's Signature: _____

Date:_____ Time(EST):_____ ID Verification Signature # 1: _____

Date:_____ Time(EST):_____ ID Verification Signature # 2: _____

RFLP ordered on product? (***Check ONE***) Yes _____ No _____

Instructions for Completion of Cellular Therapy Infusion Form

- Record Infusion Date when it has been determined.
- Attach patient and/or donor identification labels in allotted space.
- Select type of Cellular Therapy Product being infused to the recipient.
- Reinfusion Barcode # field: Attach ISBT-128 product barcodes. If multiple bags are being infused, apply additional barcodes on the form and reflect which bags were infused
- Description of Product: Check appropriate boxes to reflect Autologous, Allogeneic, Syngeneic and product type; use "Other" for study products under IND, granulocytes, etc.
- Collection Date: Include all applicable collection dates
- Expiration Date: Enter Expiration Date (if applicable)
- # of Bags : Include the # of bags (if multiple bags thawed)
- Total Volume: Enter the total volume of the product to be infused.
- Total Nucleated Cell Count (TNCC): Enter the TNCC of the product to be infused.
- Total Cell Dose: Enter the cells dose (x 10e8 cells/kg) of the product to be infused
- CFU-GM: Place an "*" in that location and comment "* Results to follow"
- CFU-GEMM: Place an "*" in that location and comment "* Results to follow"
- CFU-BFUE: Place an "*" in that location and comment "* Results to follow"
- Total CD34+ Dose *(fresh)*: Enter the total CD34 dose (x 10e6/kg) *(if applicable)*
- Total CD34+ Dose *(pre-freeze)*: Enter the "pre-freeze" CD34+ dose(x 10e6/kg *(if applicable)*
- Thawing and Infusion as per Protocol#: Enter Dextran Albumin Thaw (*if applicable*), 37 degree Celsius Thaw (*if applicable*), or Not Applicable (*if not thawing cells*).
- Single, Tandem Transplant or Tissue Transplant Check ONE that is applicable
- Requesting Physician: Obtain Signature of attending MD taking responsibility for this infusion
- ID# : This reflects the MD's pager # who is signing the order
- Date: Reflects the date the MD signed the infusion form
- Special Instructions: Enter the specific instructions with regards to the product being infused (Ex. DAT cells as per SOP; QC to include: cell counts, viability, HPC assay, flow cytometry (CD3, 4, 8, 34), and bacterial cultures".
- Back Up: Enter amount of product available as a backup.
- Viability(%): Include the viability of the product infused.
- Total Viable Nucleated Cell Count (TNCC): Enter the viable TNCC of the product to be infused.
- Percent Recovery post thaw and/or manipulation: Enter the percent recovery of the product to be infused if it was thawed or manipulated.
- Date:_____ Time: _____ Delivery Person's Signature: Enter the date, time, and signature of the person delivering the cells to the Transplant Facility.
- Date:_____ Time: _____ Recipient Person's Signature: Enter the date, time, and signature of the person receiving the cells at the Transplant Facility.
- Date:_____ Time: _____ ID Verification Signature #1: Enter the date, time, and signature of the person confirming the identification/labeling of cellular product at the Transplant Facility.
- Date:_____ Time: _____ ID Verification Signature #2: Enter the date, time, and signature of second person confirming the identification/labeling of the cellular product at the Transplant Facility.

Signature Manifest

Document Number: STCL-FORM-056 **Revision:** 07

Title: Cellular Therapy Infusion Request Form

All dates and times are in Eastern Time.

STCL-FORM-056 Cellular Therapy Infusion Request Form

Author

Name/Signature	Title	Date	Meaning/Reason
Barbara Waters-Pick (WATE02)		03 Oct 2019, 11:35:55 AM	Approved

Management

Name/Signature	Title	Date	Meaning/Reason
Barbara Waters-Pick (WATE02)		03 Oct 2019, 11:38:15 AM	Approved

Medical Director

Name/Signature	Title	Date	Meaning/Reason
Joanne Kurtzberg (KURTZ001)		03 Oct 2019, 01:03:37 PM	Approved

Quality

Name/Signature	Title	Date	Meaning/Reason
Lisa Eddinger (LE42) Richard Bryant (RB232) Taylor Orr (TSO4) (LE42) for Bing Shen (BS76) Isabel Storch (IMS19)		03 Oct 2019, 01:48:45 PM	Approved

Document Release

Name/Signature	Title	Date	Meaning/Reason
Sandy Mulligan (MULLI026)		07 Oct 2019, 12:27:19 PM	Approved