**Document Information**

<table>
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<tr>
<th>Revision</th>
<th>Vault: STCL-Form-rel</th>
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<tr>
<td>Status: Release</td>
<td>Document Type: STCL FORM</td>
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**Date Information**

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<tr>
<th>Creation Date: 03 Jan 2018</th>
<th>Release Date: 16 Feb 2018</th>
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<td>Effective Date: 16 Feb 2018</td>
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**Control Information**

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<tr>
<th>Author: WATE02</th>
<th>Owner: WATE02</th>
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<tr>
<td>Previous Number: STCL-PROC-029 Rev 05</td>
<td>Change Number: STCL-CCR-410</td>
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Cellular Therapy Infusion Request Form

Infusion Date: __/__/______

PATIENT IDENTIFICATION: LABEL FROM STCL

*********************************************************************************************************************************************
HEMATOPOIETIC or CELLULAR THERAPY PRODUCT
AUTLOGOUS BONE MARROW ALLOGENEIC BONE MARROW MSCs
PERIPHERAL BLOOD STEM CELLS UMBILICAL CORD BLOOD GRANs
PARATHYROID TISSUE THYMUS TISSUE OTHER

Reinfusion Accession #: __________________________ 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: _________ x10^3 / kg (if available)
CFU-GMEM Dose: _________ x10^3 / kg (if available)
CFU-BFUE Dose: _________ x10^3 / kg (if available)
Total CD34+ Dose: _________ x10^6 / kg
Total CD34+ Dose (pre-freeze): _________ x10^6 (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 designer, 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 _________

STCL-FORM-056 Cellular Therapy Infusion Request Form
Stem Cell Laboratory, DUMC
Durham, NC

CONFIDENTIAL - Printed by: ACM93 on 16 Feb 2018 08:23:40 am
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 Accession # field: Attach ISBT-128 product barcodes. If multiple bags are being infused, apply additional barcodes to the bottom and/or back of the form.
- Description of Product: Write detailed description of the product being infused (Examples: Unrelated Umbilical Cord Blood, Granulocytes, Allogeneic, Red Cell Depleted PBPCs, Thymus tissue, Parathyroid tissue, Mesenchymal Stem Cells (MSCs), Other, 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 10^8 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: Enter the total CD34 dose (x 10^6/kg)
- Total CD34+ Dose (pre-freeze): Enter the “pre-freeze” CD34+ dose
- 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 #
- 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.

STCL-FORM-056 Cellular Therapy Infusion Request Form
Instructions
Stem Cell Laboratory, DUMC
Durham, NC
# STCL-FORM-056 Cellular Therapy Infusion Request Form

## Author

<table>
<thead>
<tr>
<th>Name/Signature</th>
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<th>Meaning/Reason</th>
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<tr>
<td>Barbara Waters-Pick</td>
<td></td>
<td>30 Jan 2016, 03:02:44 PM</td>
<td>Approved</td>
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## Manager

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<td>Joanne Kurtzberg</td>
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<td>30 Jan 2016, 06:26:58 PM</td>
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<tr>
<td>Richard Bryant</td>
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<td>31 Jan 2016, 07:28:54 AM</td>
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<td>Sandy Mulligan</td>
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<td>04 Feb 2016, 05:58:29 PM</td>
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