DOCUMENT NUMBER: STCL-FORM-056

DOCUMENT TITLE:
Cellular Therapy Infusion Request Form

DOCUMENT NOTES:

Document Information

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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: ____/____/_____

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: ____/____/_____

# Bags: ____/____/_____

# Bars:

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

Total Cell Dose: ______________ x10^6 / 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 _______

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

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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 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 (fresh): Enter the total CD34 dose (x 10^6/kg) (if applicable)
- Total CD34+ Dose (pre-freeze): Enter the “pre-freeze” CD34+ dose x 10^6/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.

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

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# Signature Manifest

**Document Number:** STCL-FORM-056  
**Title:** Cellular Therapy Infusion Request Form  

All dates and times are in Eastern Time.

## STCL-FORM-056 Cellular Therapy Infusion Request Form

### Author

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<th>Meaning/Reason</th>
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<tr>
<td>Barbara Waters-Pick (WATE02)</td>
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<td>03 Oct 2019, 11:35:55 AM</td>
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### Management

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### Medical Director

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<td>Joanne Kurtzberg (KURTZ001)</td>
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### Quality

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<td>Richard Bryant (RB232)</td>
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<td>Taylor Orr (TSO4)</td>
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<td>(LE42) for Bing Shen (BS76)</td>
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