PHYSICIAN REQUEST FOR COVID-19 CONVALESCENT PLASMA

I, __________________________, am requesting COVID-19 Convalescent Plasma for my patient,

(Physician’s Name)

________________________ admitted at ________________________________.

(Patient’s Name) (Hospital Name)

In addition to meeting all requirements for Allogeneic Blood Donation, I understand the donor(s) must also meet the additional FDA criteria as follows:

- Prior diagnosis of COVID-19 documented by a laboratory test. **Date of Positive Test:** ________
- Complete resolution of symptoms at least 14 days prior to donation.
- Are either male donors, or female donors who have never been pregnant for female donors negative for HLA antibodies.
- Negative results for COVID-19 either from one or more nasopharyngeal swab specimens or by a molecular diagnostic test from blood. **Date of Negative Test:** ________
- Have SARS-CoV-2 neutralizing antibody titer >1:320 (if test was performed).
- Be ABO Plasma compatible with the patient.

**Name of Donor(s):**

1. __________________________________________
2. __________________________________________
3. __________________________________________
4. __________________________________________
5. __________________________________________
6. __________________________________________
7. __________________________________________
8. __________________________________________
9. __________________________________________
10. __________________________________________

**Physician’s Statement:**

I certify that the donor(s) listed meet the above FDA criteria and the information provided is correct.

Please select 1 of the following:

☐ I certify that FDA Approval has been provided to the Coastal Bend Blood Center.
☐ I have received verbal approval from the FDA under the following IND#____________________

**Physician’s Name (Printed):** ______________________________________________________________

**Texas Medical License #:** ________________________________________________________________

**Signature:** ____________________________________________________ **Date:** _______________

**Comment(s):** ________________________________________________________________

________________________________________

Fax Information to 361.289.1611, Attention - Quality Assurance.

Contact Coastal Bend Blood Center On-Call MD for questions at 817.482.9446.

Coastal Bend Blood Center 04/02/2020