PHYSICIAN REQUEST FOR COVID-19 CONVALESCENT PLASMA

Coastal Bend Blood Center
Giving so that others may live

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. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 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.