CHECKLIST FOR THE THAWING AND ADMINISTERING OF FROZEN CELLS

Please return the completed form to the Stem Cell Laboratory in the red blood transfusion box.

Patient's name | **Date** | **Tag No.**

Hospital number | **Transplant issued by**

DOB | **Number of bags issued**

Product

Please complete boxes and sign at the bottom of the sheet.	**Unit number**		**Unit Number**	
	Bag 1	**Bag 2**	**Bag 1**	**Bag 2**
Patient's details checked				
Doses checked against transplant proforma and report, including total dose when there is more than one bag				
Bag and seals checked and intact				
Temperature of water bath at start °C				
Time thawing commenced				
Time thawing complete				
Temperature of water bath on completion °C				
Patients wristband checked				
Time infusion commenced				
Time infusion complete				

Adverse reactions and/or other problems/comments? YES/NO
(Please specify bag and unit and detail any steps taken to remedy, continue on back of form if necessary)

Incident number if reported

NB any serious adverse events or reactions must be reported to the HTA within 24 hours- notify the Laboratory manager **ASAP**.

SAMPLE

Staff thawing	Name
	Signature
Checked by	Name
	Signature

SAMPLE