



# Medical Assessment of patients for bone marrow harvest or therapeutic apheresis

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## Cellular Therapy and Transplant Programme Medical Assessment of CAR-T **Patients**

NILIC	Found	1-4:	Turnet
	FOLIDA	IATION	IFFICT

Patient addressograph:			Height cms: Weight kgs:				
•							
			Data				
Name: Numb	er:		Date:				
DOD.							
DOB: Address:			PO number				
Address.			LYM number: NCCP:				
			Date to panel:				
			·				
			-				
MEDICAL ASSESSMENT:							
Review of Systems: Please tick Yes/N	No where a	ppropriat	e				
	Yes	No	<u> </u>		Yes	No	
Fever/sweats	162	INO	Fits / Faints / Falls / Pares	thesia	162	INO	
Chest pain/palpitations	1		Back pain / joint pain	lilesia			
SOB/Cough / Wheeze / Sputum /			Hyperviscosity/ hyperleuco	octopio			
Haemoptysis			Hyperviscosity/ Hyperieuco	วรเสรเร			
Adbo pain / N+V / Hematemesis			Bleeding / bruising				
Change in bowel habit / Malaena			Smoker/day				
Urinary symptoms?			Alcoholunit/wee	ek			
Headache/visual problems			7 (100)101				
Pre Cart biopsy date:		Pre CA	.RT PET scan date :				
The Galt Stopey date.		1.007	Zi odan dato i				
Details							
Disease History:							
Diagnosis, treatment and remission sta	ıtus:						
Previous History: if yes provide deta	nils						
, , , , , , , , , , , , , , , , , , ,	Yes	No			Yes	No	
Cardiac or circulatory disease	162	NO	General Anaesthetic		162	INO	
Respiratory disease			Hepatitis, HIV, syphilis				
Diabetes Mellitus	1	1	Piercing / Tattoos last 3 mo	nths			
Acupuncture (past 3 months non-UK			Travel outside of Europe in				
		last year					
		Malaria risk					
Jaundice							
Details:							



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Medication							Allergies?	•	
Allergies					•				
Previous C					G-CSF / cytokine?:				
General Ex	amination	n:							
Pulse:		Temp:		BP:	RF	R:		SaO <sub>2</sub> :	
CVS:		<u>'</u>			Abo	odo:			
CNS:			Musculoskeletal: Liv			Live	ver/spleen:		
0.10.		Waddio Nototal.							
Washout c	riteria clinic	cian to complete	in clini	C					
3 days							☐ Yes	□ No	
5 days	Has patient received short acting growth						☐ Yes	□ No	
7 days	Has the patient received steroids?						☐ Yes	□ No	
7 days Has the patient received IT Methotrexate					☐ Yes	□ No			
	Has the patient received low dose maintenance chemotherapy? (6MP/MXT/vincristine)								
	TKI therapy								
14 days	ays Blinatumomab GVHD treatment				☐ Yes	□ No			
Lenolidamide									
	Immune modulatory therapy including checkpoint inhibitors Radiotherapy								
Has the patient received Peg asparaginase									
4 WEEKS	Antibody therapy including CD20 specific treatments (rituximab, inotuzumab)					☐ Yes	□ No		
8 weeks	Has the patient received clofarabine T cell Lytic agents ( Alemtuzumb)					☐ Yes	□ No		
12 weeks	Has the patient received Fludarabine Undergone an allogeneic transplant?					☐ Yes	□ No		
Other	Has the patient ever received Bendamustine treatment					☐ Yes	□ No		
Other	<b>Tecartus only:</b> Stop systemic therapies 2 weeks or 5 half-lives (whichever is shorter)						☐ Yes	□ No	



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Clinician to tick to confirm results have been reviewed as stated above:							
FBC	Yes □						
Urine dipstick analysis if inc	Yes □ N/A □						
Blood film (only if indicated	Yes □ N/A □						
Clotting screen			Yes □				
Christie Profile	Yes □						
Glucose	Yes □						
Blood group and antibody s	screen		Yes □				
Pre-harvest viral serology	Yes 🗆						
Other serological testing as	Yes □ N/A □						
ECG	Yes □						
PA chest X-ray (if indicated	Yes □ N/A □						
MRSA screen and eradicat	Yes □ N/A □						
Other investigations (visco	osity, cardiac, renal etc if	indicated):	<u> </u>				
Peripheral Venous Access:							
LEFT	EFT GOOD / POOR/femoral RIGHT		GOOD / POOR/femoral				
Medically fit to donate? :	Yes No	Signature:	Name:				
Written and verbal information given regarding the risks of HPC donation? : Yes No							
FINAL ASSESSMENT: (to be conducted by collection facility medical director or designee)							
Passed final assessment?:	Yes No	Cinnatura	Nama				
Reason for Failure:		Signature:	Name:				
TIGASUITIUI FAIIUIE.		Date:	Time:				

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Cellular Therapy collection prescription and request for product						
<u>processing</u> – to be completed by the clinician and sent with product						
Please arrange collection for						
-						
Bertant Plate to an inches						
Patient likely to require central venou  Product	s catheter?:	⊔ Yes ⊔ No				
	_					
☐ Kymriah (NOVARTIS)	☐ Tecartus (0	GILEAD)				
☐ Yescarta (GILEAD)	☐ Other (plea	se state):				
☐ Trial (please specify)						
Specific product requirements						
Number of collections allowed:   1	□ 2					
TBV to be processed if stated						
Maximum or minimum collect volume	if stated					
Waximum of minimum concer volume	n stated					
Concurrent plasma to be collected: [	☐ Standard	☐ Into product	☐ Not required			
Containent placina to as contained		<b>o</b> p. o a a a c				
Cells to be transported: ☐ Fresh ☐ Cryopreserved						
Target collection Dose if stated: CD3+ TNC: MNC:						
Target collection bose il stated. Cbs	+ 1110	IVINO				
FOR Kymriah/tisagenlecleucel collect requirements						
Optimal collect range of 1.5 - 4 x10/9 CD3 cells but ideally greater than 2 and minimum for acceptance of 1						
Greater than or equal to 2 x10/9 TNC At least 3% of TNC being CD3+ cells						
At least 5 % of TNO being 0254 cens						
Any other Specific collection requiren	nents:		 T			
Clinicians Signature:	Name:		Date:			
Jugitature.	ivallie.		Dale.			