- ***Form No. : 1***

  Convalescent Plasma COVID-19 Donor Registration/Consent Form

  Please fill out the form below, and we will contact you as soon as possible.

  Once we determine that you are eligible to donate, we will send your contact information to a collection site near you to schedule your donation.

NAME:					
	First		Middle		Last
Email:				Phone No.:	
Age/Sex:		Address:			
1. Was your COVID-19 diagnosis confirmed by a lab test by PCR method?					
Yes	No	I don't Know			
2. Do you currently have symptoms?					
Yes	No				
3. Has it been at least 14 days since the last day of your symptoms (COVID-19 symptoms include fever, cough and shortness of breath)?					
Yes	No				
4. Date of complete resolution of symptoms: ..../........./...........					
5. Have you had a follow up test that was negative for COVID-19 through PCR method ?					
Yes	If Yes, ☐ 1 time or ☐ 2 times		I don't know		
6. Have you had a follow up test that was positive for serological test of SARS-CoV-2 antibodies?					
Yes	No	I don't know			

I hereby certify that I have answered the above question truthfully and that to the best of my knowledge. I hereby voluntarily donate blood to the blood transfusion service centre of Nepal without expecting any type of remuneration. The blood may be given to any patient or use for research purpose as deemed suitable by the blood transfusion centre of Nepal. I have already received information from my treating physician about both benefits and adverse effect of blood donation and I am willing to donate blood.

Donor's Signature : ....

Date of Submission: ....

Co-ordinator for CCP:.....................................

Signature:....................................

Date:...

- ***Form :2***

Convalescent Plasma COVID-19 Request Form

Thank you for reaching out to us
Please tell us about your interest in convalescent plasma.

Reason for your inquiry:			
Does your inquiry involve a patient with an urgent need?			
Name:			
Email:		Phone No.:	
Name of institution or practice			
Address:	Blood group:		
Comments:			

FORM: 3

CONSENT FORM FOR TRANSFUSION OF CONVALESCENT PLASMA FROM RECOVERED COVID-19 PATIENTS

Name of the Hospital:____

Patient's Name :………………………………………………………………………………………… **Age/Sex:**……………………………………

Reg No. : ……………………………… **Ward/Bed No. :**………………………..

Transfusion of convalescent plasma from recovered COVID-19 patients is a life saving medical procedure.

1. I/My patient have/has been informed of the transfusion options available and expected benefits of transfusion of plasma from recovered COVID-19 patients
2. I/My patient agree/s to the administration of blood components in the interest of proper medical care.
3. I/My patient understand/s that blood components to be administered have been prepared and tested in accordance with safety regarding transfusion transmissible diseases. However, there is still a very small chance that an adverse reaction can occur such as: fever with or without chills and rigor, itching, hives and other treatable conditions. Rarely an unpredictable life threatening event can also occur.
4. I/My patient have/has been informed that despite mandatory screening for blood-borne infections such as HIV, Hepatitis B, Hepatitis C and Syphilis, the risk of acquiring these infections is not totally eliminated.
5. I/My patient have/has had the opportunity to ask questions about transfusions, alternatives to transfusion, risk of not transfusing, the procedures to be used and the relative risks and hazards involved.
6. *I/My patient believe*/s that I/my patient have/has been sufficiently informed to make a decision to give consent for transfusion of blood/blood components.
7. I/My patient have/has been informed and explained regarding the prepared plasma without the defined SARS-CoV-2 neutralizing antibody titters.
8. I/My patient have/has been informed and explained the above in a language that I/My patient understand/s.

AUTHORIZATION BY PATIENT

Name of the Patient: ______________________________________ Signature/Thumb Impression: __________

Name of Witness:____ Signature/ Thumb Impression: __________

PATIENT'S ATTENDANT/NEXT TO KIN

The patient is unable to give consent because ____ And I ____ (name/relationship to the patient), therefore consent for the patient. I acknowledge that I have had an opportunity to discuss this procedure, as stated above, with my physician, physician designee and hereby consent to this procedure.

Signature/Thumb Impression of Patient's Attendant: ________________________________

Doctor : ____ Designation: _________________

Date: _________________________ Signature : __________________

- ***Form No. : 4***

Convalescent Plasma COVID-19 Donor Screening Form

Please fill out the form below.

NAME:				
	First		Middle	Last
Email:			Phone No.:	
Age/Sex:		Address:		
7. Was your COVID-19 diagnosis confirmed by a lab test by PCR method?				
Yes	No	I don't Know		
8. Do you currently have symptoms?				
Yes	No			
9. Has it been at least 14 days since the last day of your symptoms (COVID-19 symptoms include fever, cough and shortness of breath)?				
Yes	No			
10. Date of complete resolution of symptoms: ..../........./............				
11. Have you had a follow up test that was negative for COVID-19 through PCR method ?				
Yes	If Yes, ☐ 1 time or ☐ 2 times	I don't know		
12. Have you had a follow up test that was positive for serological test of SARS-CoV-2 antibodies?				
Yes	No	I don't know		

I hereby certify that I have answered the above question truthfully and that to the best of my knowledge. I hereby voluntarily donate blood to the blood transfusion service centre of Nepal without expecting any type of remuneration. The blood may be given to any patient or use for research purpose as deemed suitable by the blood transfusion centre of Nepal. I have already received information from blood transfusion service centre about both benefits and adverse effect of blood donation and I am willing to donate blood.

Donor's Signature : .... Date of Submission: ....

Involved doctor/ Technical Personnel's name:............................

Signature:...................................... Date:.......................................