TCATF 181 02
(Relates to SOP No. TCATS CTL 003)

Patient / Lymphoma Information

Part 1 – Initial request (from requesting centre)

1.1 Requesting Physician			
Name:			
Tel :		Fax:	
Page / mobile:			
e-mail:			
Hospital: Address:			

1.2 Patient Details	
Name (underline surname)	
Date of Birth (DD/MM/YY)	
Hospital / CHI number	
UKT number (for UK patients)	
Blood group	
Weight (approx) Kg	

Details of treatment / Immunosuppression

Epstein-Barr Virus (EBV) lymphoproliferative disorder: Details, Evidence, Treatment	
Date diagnosis confirmed	

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Part 2 – Additional information (from requesting centre)

2.1 HLA Type:	
Patient Name	
Patient HLA type	please send a copy of the patient's HLA type report
Transplant donor HLA type	please send a copy of the transplant donor's HLA type report, if available
Name / contact details of HLA testing laboratory	

2.2 Transplant History	**Transplant 1**	**Transplant 2**
Organ(s) transplanted		
Date of transplant(s)		
HLA type of donor(s)		
Mismatch		
Organ donor cells and DNA available	YES / NO	YES / NO

2.3 Patient Sensitisation History (Include any HLA antibodies identified)	
Date	**Sensitising event (transfusion, pregnancy, transplantation)**
Please send a copy of the most recent HLA antibody test results, if available	

2.4 Form completed by:			
Name		**Designation**	
Signature		**Date**	

Return form + reports to: CTL Staff, TCAT, SNBTS, The Jack Copland Centre, Edinburgh, EH14 4BE
Scan/Email: nss.ctlbank@nhs.net (Fax: 0131 314 5799)

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Part 3 – Patient review (for CTL BANK USE ONLY)

3.1 Checklist of initial points discussed (Internal Use only)			
Patient Name			
Is request relevant?	Yes/No Comment:	Init.....	Date.....
Are potential CTLs available?	Yes /No/Not Known Comment:	Init.....	Date.....
3.2 Following points to be discussed with requesting clinician			
Licensed product forms TCATF 183 & TCATF 190	Yes/No Comment	Init.....	Date.....
Form TCATF 189 will be sent for patient information & consent	Yes/No Comment	Init.....	Date.....
Cost recovery charge explained	Yes/No Comment	Init.....	Date.....
Pre-CTL testing Blood samples and completion of TCAT TCATF 182	5-10ml Clotted sample 5-10ml EDTA (or Buccal smear paediatric)	Init.....	Date.....
3.3 Follow up sample			
Blood sample requested 12 weeks post final CTL	5-10ml Clotted sample 12 wk post Yes/No Comment	Init.....	Date.....
3.4 Further information			
Further comments / reason for rejection			

Name		**Designation**	
Signature		**Date**	