



**TCATF 184 02**  
(Relates to SOP No. TCATS CTL 003)



**CTL Treatment Protocol**

**EBV-specific CTL for treatment of EBV+ lymphoma**

Epstein-Barr Virus (EBV) specific cytotoxic T lymphocytes (CTL) are supplied for treatment of EBV-positive lymphoma. They are cultured from tissue typed blood donors, stored frozen in vapour-phase liquid nitrogen at  $<-150^{\circ}\text{C}$  and selected for patient treatment on the basis of best available HLA match. The anti-EBV CTL product is not licensed for marketing and is supplied on a named patient basis only.

Treatment normally involves 4 infusions of CTL at weekly intervals. Sufficient CTL for 4 infusions will be shipped together and must be transferred to suitable storage and kept frozen preferably in nitrogen vapour at  $<-130^{\circ}\text{C}$  until each treatment is to be given.

Note: cells are supplied only for use on a named patient basis. Any unused cells must be discarded.

**EBV-specific CTL supplied**

Product name: EBV-specific CTL

Description: cultured cells are supplied cryopreserved with 10% dimethyl sulphoxide (DMSO) and in 10% human albumin solution (HAS).

Packaging: the cells are supplied in double wrapped cryobags containing approximately 15ml of either 50 or 150  $\times 10^6$  CTL, labelled for the named patient use only. They must be kept frozen until ready to prepare for treatment.

**Delivery of EBV-specific CTL and transfer to local  $\leq -80^{\circ}\text{C}$  storage**

The frozen CTL are transported in a 'dry shipper' (vapour-phase liquid nitrogen container) marked for the attention of a nominated recipient with their contact details. Ensure that the contents are kept frozen, and quickly transfer to vapour phase liquid nitrogen storage. The cryobag ports are fragile when frozen. Please handle with care.

Upon receipt:

- Record the time, also temperature / status displayed on logger;
- Check that the number of bags corresponds to the number detailed below;
- Check that the labels visible inside the outer bag have the correct patient named;
- Check for any obvious damage (other than a small cut in the outer bag) or signs of thawing (record on page 5).

Please copy/scan or fax completed page 5 back to us and report any concerns to CTL staff in Edinburgh (Tel: 0131 314 5545) as soon as possible. Any suspect cryobags must be double bagged / quarantined.

**Patient consent**

A patient information and consent form is provided as a basis for discussion between the patient or guardian with the treating physician. The signed original should be kept in the patient notes. Two copies are required: one for the patient and one for SNBTS, Edinburgh.



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**Method for infusion of EBV-specific CTL**

For the number of bags required per treatment, refer to page 5, the personalised section of this form below. Approximately  $1-2 \times 10^6$  CTL/kg body weight should be given at each infusion ( $50 \times 10^6$  CTL per 25kg body weight). This may involve using only a portion of the bag contents to achieve  $1-2 \times 10^6$  CTL/kg body weight. Keep the bag(s) frozen until everything is ready for the treatment. The cryoprotectant DMSO is harmful to metabolising cells so aim to infuse soon after thawing, or keep thawed cells cool ( $<10^\circ\text{C}$ ) if delayed.

**You will need (on each day of infusion)**

**Materials:**

- $37^\circ\text{C}$  waterbath (or equivalent, eg bead bath or sterile  $37^\circ\text{C}$  incubator) freshly cleaned, filled with sterile water
- Insulated transport box / dry shipper to maintain treatment bag(s)  $< -80^\circ\text{C}$
- Insulated gloves
- Sterile wipes
- Paper towels
- Scissors
- Plastic bags
- Heat sealer
- Blood administration set – e.g. Avon ref A100
- Sterile gloves
- Plastic apron

**Method:**

1. Retrieve CTL bag(s) for one dose from storage (wear insulated gloves) to an insulated cold transport box. Check the patient detailed on the label corresponds to the patient to be treated.
2. Have the materials and the cleaned water bath ready with sterile water at  $37^\circ\text{C}$ . Ensure staff member infusing the cells and the patient are ready before commencing thawing.
3. If more than one bag is required per treatment, prepare each one separately, waiting until the previous one has been infused before thawing the next.
4. Take the (first) CTL cryobag from the transport box/nitrogen shipper. Carefully cut open the outermost bag and retrieve the double wrapped cryobag within. Keep the large label. Please note that the outer bag will have a small 1-2cm cut to prevent rapid expansion when exposed to room temperature.
5. Check the patient named on the label corresponds to the patient being treated. Place the cryobag into a further plastic bag, exclude as much air as possible and seal. (If more than one bag, retain the other(s) frozen meantime) Plunge the bag in the waterbath to thaw as rapidly as the multiple layers will allow\*. The ports are more insulating and take longer to thaw so ensure that they are fully submerged. Allow to thaw gently in the warmth and avoid any temptation to squeeze the bag contents (ice crystals may damage cells). Record thaw/waterbath temperature. Remove the bag as soon as the ice has melted (clears) paying attention to the ports. Dry the outside of the bag quickly with a clean paper towel.

\*Note: If at any stage rapid expansion of the cryocyte bag is observed during thawing, (due to ingress of  $\text{LN}_2$ ) remove from water bath, sterile wipe the bag surface and pierce the outer layers at



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the end furthest from the ports (without damaging the innermost bag) with a sterile needle. This will allow a controlled release of pressure. Record this action in the form below. Avoid submerging pierced area.

6. Carefully cut open the outer bag and retrieve the cryobag. There have been rare occasions when a bag seal has failed and the bag has leaked. If this occurs, please do not use the bag. Report as an incident and we'll send a replacement, if available.
7. Working aseptically, connect in to the blood administration set for infusion or give as bolus injection.
8. Administer intravenously over 3 to 5 minutes.
9. Complete the relevant section (pages 6-9), attach the cryobag labels. Please scan and e-mail (or copy and post) the completed infusion record with labels to [nss.ctlbank@nhs.net](mailto:nss.ctlbank@nhs.net) (or fax 0131 314 5799).

**MONITORING FOR ADVERSE EVENTS:**

- Vital signs (temperature, BP, pulse and respiration rate) should be taken twice before (at least 15 minutes apart) and every 15 minutes after injection of the cells for 1 hour and then every hour for 2 hours. Any symptoms or signs should be recorded. If no significant changes occur during the 3-hour observation period the measurement of vital signs can stop.
- To help with consistency, please use the grading system (see appendix below). Severe (grade 3) toxicity is usually an indication to stop therapy. Life-threatening (grade 4) toxicity, if attributed to the PTLD therapy, is an absolute indication to abandon therapy. Other reactions should be assessed by the treating physician for clinical significance
- Attach grade to adverse event form in the last 2 pages of the CTL treatment protocol.
- All adverse events / reactions must be reported to CTL team as soon as possible (scan and e-mail AE form to [nss.ctlbank@nhs.net](mailto:nss.ctlbank@nhs.net) (or fax to 0131 314 5799)). They, in turn, will report to SNBTS Regulatory Compliance manager.



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**BLOOD SAMPLES for HLA antibody testing**

Approximately twelve weeks post final infusion, please take a blood sample for HLA antibody testing: 5 - 10ml blood (minimum 2ml paediatric) into a plain tube for serum.

Please ensure that the tube is clearly labelled with patient identifier and date, double leakproof wrapped, with sufficient absorbent material between layers to absorb all the fluids if they leak (UN3373 Biological Substance (Category B) and Packing Instruction 650).

Please include a completed test request form (supplied), with 'CTL treatment' as the clinical condition.

SCOTTISH NATIONAL BLOOD TRANSFUSION SERVICE HISTOCOMPATIBILITY AND PLATELET IMMUNOHAEMATOLOGY ROYAL INFIRMARY, LITTLE FRANCE CRESCENT, EDINBURGH, EH16 4SA Tel: 0131 242 7528 Fax: 0131 242 7530 Email: NSS.handi@nhs.net Lab hours: Monday to Friday 0830-1700hrs			
<small>Request forms and samples not labelled in accordance with SNBTS sample acceptance policy may not be tested (see reverse of form)</small>			
<b>Patient / donor information</b> Hospital / CHI no: <input type="text"/> Surname: Forename (in full): DOB: <span style="float: right;">M/F</span> Hospital / ward: Clinical condition:  <small><b>**Samples must be labelled with the patient's full name, DoB and CHI number – an alternative unique identifier (hospital number or emergency number) may be used if the patient does not have a CHI number.</b></small>	<b>Solid organ transplant (including islets)</b> <b>Initial / confirmatory HLA type:</b> 5ml EDTA <input type="checkbox"/>  <b>HLA antibody screen (inc DSA investigation):</b> 10ml clotted <input type="checkbox"/>  <b>Initial (Virtual) crossmatch:</b> 10ml EDTA (donor) <input type="checkbox"/> 10ml EDTA and 10ml clotted (recipient) <input type="checkbox"/>  <b>Final 'wet' crossmatch:</b> (by prior arrangement only) 40ml EDTA (donor) <input type="checkbox"/> 40ml EDTA and 10ml clotted (recipient) <input type="checkbox"/>  <small><b>*Please complete one request form for donor and one for recipient</b></small>	<b>Platelet refractoriness / FNAIT</b> <small><b>**ALL SAMPLES MUST BE HANDWRITTEN**</b></small> All tests must be arranged via BTS duty haematologist (Daytime #2215 / OOH – switchboard 0131 242 1000)  <b>Platelet refractoriness:</b> 5ml EDTA + 10ml clotted (HLA/HPA type and antibody investigation) <input type="checkbox"/>  <b>FNAIT investigations:</b> <small>(also complete FNAIT form available on NHS Lothian Intranet)</small> Mother: 5ml EDTA + 10ml clotted <input type="checkbox"/> Child: 5ml EDTA <input type="checkbox"/> <small>*Smaller sample volume for paediatric patients by arrangement</small> Father (if required): 5ml EDTA <input type="checkbox"/>	<b>Disease association testing</b> <b>**All 5ml EDTA**</b> HLA B27 <input type="checkbox"/> Narcolepsy <input type="checkbox"/> Coeliac <input type="checkbox"/> HLA B*57:01 <input type="checkbox"/> Other – please specify <input type="checkbox"/> .....  <b>Lab use only</b> Date / time received:  Accepted by:  Checked by:  Sub-aliquoted by:  Archive location(s): Serum - S DNA - D
<b>Requesting clinician:</b> Contact details (bleep no./ ext):  Sample taken by: Date and time: Routine / urgent* Risk of infection: <span style="float: right;">Yes/No</span> <small>Please contact lab directly if result is required urgently</small>			

Please send to:  
 Dr David Turner,  
 H&I, Edinburgh SE Scotland Blood Transfusion Service,  
 Royal Infirmary of Edinburgh,  
 Old Dalkeith Road,  
 Edinburgh,  
 EH16 4SA

T: 0131 242 7534 / 7528

As part of a follow up / review programme and as part of required pharmacovigilance, further patient information may be requested. This will remain confidential.



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**EBV-specific CTL supplied for named patient**

EBV-specific CTL supplied			
CTL batch code number:		Patient first name surname	
Total number of bags:		D.o.B.	
Number of CTL per bag:		Other identifier	
Number of bags per treatment:		Patient weight (kg)	

Prepared by					
Name:		Signature:		Date:	

**Receipt of EBV-specific CTL**

Receipt of CTL			
Date/Time of receipt:		Security Tag Number:	Tag intact: Yes / No*
Number of bags:		Time of transfer to storage:	
Storage location: LN <sub>2</sub> or -80°C		Patient details correct:	Yes / No*
Temperature display / indication when transferred		Bags Intact and no damage: (includes breaks, tears, leaks <sup>1</sup> )	Yes / No*

<sup>1</sup> Outer bag will have a small cut to prevent rapid expansion.

\*If No or non satisfactory, contact Edinburgh SNBTS CTLbank team and comment below  
(Tel: 0131 314 5545 or e-mail: nss.ctlbank@nhs.net)

<b>Comment</b>					
<b>Name:</b>		<b>Signature:</b>		<b>Date:</b>	

Please scan completed page and e-mail to nss.ctlbank@nhs.net (or fax to 0131 314 5799).



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**Preparation for Infusion 1 : documentation**

Surname:		Forename	
Date of Birth:		ID number.	

Prior to infusion					
Patient information and consent (form TCATF 189) signed: Yes/No*					
Please indicate patient health status prior to infusion: (4 point Modified International Prognostic Index)					
Stage		ECOG (0-4) performance status		LDH Elevated / normal	

Infusion 1 : EBV-specific CTL			
Date of infusion:		Patient details correct?	Yes / No*
Time of thawing:		Contents frozen before thawing?	Yes / No*
Preparation satisfactory?	Yes / No*	Time of infusion:	
Bags Intact and no damage?	Yes / No*	Thaw/waterbath temperature (°C)	
Infusion well received?	Yes / No*	Number of bags:	

\*If No or non satisfactory, contact Edinburgh SNBTS CTLbank team and comment below  
(Tel: 0131 314 5545 or e-mail: [nss.ctlbank@nhs.net](mailto:nss.ctlbank@nhs.net))

Attach labels in this space			Comment		
Name:		Signature:		Date:	

Please scan completed page + label(s) and e-mail to [nss.ctlbank@nhs.net](mailto:nss.ctlbank@nhs.net) (or fax 0131 314 5799).

CTL bank, TCAT, SNBTS, The Jack Copland Centre 52 Research Avenue North, Edinburgh, EH14 4BE	Tel: 0131 314 5545 e-mail: <a href="mailto:nss.ctlbank@nhs.net">nss.ctlbank@nhs.net</a> Fax: 0131 314 5799
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**CTL Treatment Protocol**

**Preparation for 2 : EBV-specific CTL**

Surname:		Forename	
Date of Birth:		ID number.	

Infusion 2 : EBV-specific CTL			
Date of infusion:		Patient details correct?	Yes / No*
Time of thawing:		Contents frozen before thawing?	Yes / No*
Preparation satisfactory?	Yes / No*	Time of infusion:	
Bags Intact and no damage?	Yes / No*	Thaw/waterbath temperature (°C)	
Infusion well received?	Yes / No*	Number of bags:	

\*If No or non satisfactory, contact Edinburgh SNBTS CTLbank team and comment below  
(Tel: 0131 314 5545 or e-mail: [nss.ctlbank@nhs.net](mailto:nss.ctlbank@nhs.net))

Attach labels in this space		Comment	
Name:		Signature:	
		Date:	

**Please scan completed page + label(s) and e-mail to [nss.ctlbank@nhs.net](mailto:nss.ctlbank@nhs.net) (or fax 0131 314 5799).**

CTL bank, TCAT, SNBTS, The Jack Copland Centre 52 Research Avenue North, Edinburgh, EH14 4BE	Tel: 0131 314 5545 e-mail: <a href="mailto:nss.ctlbank@nhs.net">nss.ctlbank@nhs.net</a> Fax: 0131 314 5799
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**Preparation for 3 : EBV-specific CTL**

Surname:		Forename	
Date of Birth:		ID number.	

Infusion 3 : EBV-specific CTL			
Date of infusion:		Patient details correct?	Yes / No*
Time of thawing:		Contents frozen before thawing?	Yes / No*
Preparation satisfactory?	Yes / No*	Time of infusion:	
Bags Intact and no damage?	Yes / No*	Thaw/waterbath temperature (°C)	
Infusion well received?	Yes / No*	Number of bags:	

\*If No or non satisfactory, contact Edinburgh SNBTS CTLbank team and comment below  
(Tel: 0131 314 5545 or e-mail: nss.ctlbank@nhs.net)

Attach labels in this space	Comment
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Name:		Signature:		Date:	
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**Please scan completed page + label(s) and e-mail to nss.ctlbank@nhs.net (or fax 0131 314 5799).**

CTL bank, TCAT, SNBTS, The Jack Copland Centre 52 Research Avenue North, Edinburgh, EH14 4BE	Tel: 0131 314 5545 e-mail: nss.ctlbank@nhs.net Fax: 0131 314 5799
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**CTL Treatment Protocol**

**Preparation for 4 : EBV-specific CTL**

Surname:		Forename	
Date of Birth:		ID number.	

Infusion 4 : EBV-specific CTL			
Date of infusion:		Patient details correct?	Yes / No*
Time of thawing:		Contents frozen before thawing?	Yes / No*
Preparation satisfactory?	Yes / No*	Time of infusion:	
Bags Intact and no damage?	Yes / No*	Thaw/waterbath temperature (°C)	
Infusion well received?	Yes / No*	Number of bags:	

\*If No or non satisfactory, contact Edinburgh SNBTS CTLbank team and comment below  
(Tel: 0131 314 5545 or e-mail: nss.ctlbank@nhs.net)

<p>Attach labels in this space</p>	<p>Comment</p>	
Name:	Signature:	Date:

Please scan completed page + label(s) and e-mail to [nss.ctlbank@nhs.net](mailto:nss.ctlbank@nhs.net) (or fax 0131 314 5799).

CTL bank, TCAT, SNBTS, The Jack Copland Centre 52 Research Avenue North, Edinburgh, EH14 4BE	Tel: 0131 314 5545 e-mail: <a href="mailto:nss.ctlbank@nhs.net">nss.ctlbank@nhs.net</a> Fax: 0131 314 5799
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**Appendix Grading of acute and subacute toxic effects**

Toxicity	Mild 1	Moderate 2	Severe 3	Life-threatening 4
<b>Systemic</b>				
Fever (°C)	<38.5	38.5 - 40	>40	>40 + hypotension
Chills	Mild - mod	Severe	Rigors <2 hr	Rigors >2 hr
Skin	M-p rash <25% of body	Rash 25-50% of body	Gen. erythroderma	Exfoliative dermatitis, bullae
Allergy	Transient rash	Urticaria, drug fever >38°C	Bronchospasm or serum sickness	Anaphylaxis
<b>Haematological*</b>				
Hb - g/dl	9.5 - 10.9	8.0 - 9.4	6.5 - 7.9	<6.5
PMN x 10 <sup>9</sup> /L	1.3 - 2.0	0.75 - 1.29	0.5 - 0.74	<0.5
Platelet x10 <sup>11</sup> /L	75 - 100	50 - 74	25 - 49	<25
Haemorrhage	Petechiae	Mild loss	BT <4 units	BT ≥4 units
<b>GI/Hepatic</b>				
Nausea & vomiting	Nausea	Vomiting	Vomiting + iv Rx	Intractable
Diarrhoea (ml/day)	Stool >500	Stool >1000	Stool >1500	Haemorrhagic or stool >2000
Bilirubin x N	1.25 - 2.0	2.1 - 3	3.1 - 5	>5
AST x N	1.25 - 2.5	2.6 - 5	5.1 - 20	>20
Amylase x N	1.25 - 2.0	2.1 - 3	3.1 - 5	>5
ALP x N	1.25 - 2.5	2.6 - 5	5.1 - 20	>20
<b>Renal</b>				
Creatinine x N	1.25 - 2	2.1 - 3	>3	Needs dialysis
Proteinuria g/d	0.25 - 2	2.1 - 5	>5	Nephrotic syndrome
Haematuria	Microscopic	Gross	Gross + clots	Needs transfusion
<b>Neurological*</b>				
Central	Poor memory	Confusion or lethargy	Disorientation or stupor	Coma and/or seizures
Peripheral	Paraesthesia ↓ DTR	Absent DTR + weakness	+++ weakness	Paralysis
Headache	Mild, untreated	With analgesia	With narcotic	Intractable
Constipation	Mild	Moderate treated	Abdominal distension	Distension and vomiting
<b>Pulmonary*</b>				
	Mild	SOBOE	Dyspnoea at rest	Bedridden
<b>Cardiac</b>				
Rhythm	ST >110 at rest	Unifocal PVC atrial arrhythmia	Multifocal PVC	Ventricular tachycardia
Function	Abnormal signs	Untreated dysfunction	Treated dysfunction	Unresponsive to therapy

\*These values may be age dependent and/or are difficult to assess in children  
N = upper end of normal range



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**Reporting of adverse events or reactions**

Any adverse event / reaction must be reported immediately to CTL team by e-mail [NSS.ctlbank@nhs.net](mailto:NSS.ctlbank@nhs.net) (or fax to 0131 314 5799). Tel 01224 812 401 or 0131 314 5545.

Serious adverse event arising from the use of Human Cells as the starting material (As per EUTCD 2004/23/EC)	Any untoward occurrence which may be associated with the procurement, testing, processing, storage or distribution of tissue or cells intended for human application and which, in relation to a donor of tissue or cells intended for human application or a recipient of tissue or cells: – (a) <b><u>might</u></b> lead to the transmission of a communicable disease, to death or life-threatening, disabling or incapacitating conditions, or (b) <b><u>might</u></b> result in, or prolong, hospitalisation or morbidity
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Serious adverse reaction from the use of the unlicensed medicinal product	Any reaction associated with the use of the antiEBV CTL product which <b><u>might</u></b> lead to death or life-threatening, disabling or incapacitating conditions, result in, or prolong, hospitalisation or morbidity or any other medically significant adverse reaction including (but not restricted to the transmission of a communicable disease
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**PLEASE COMPLETE ONE FORM FOR EACH ADVERSE EVENT / ADVERSE REACTION**



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**CTL Treatment Protocol**

**PLEASE COMPLETE ONE FORM FOR EACH ADVERSE EVENT / REACTION**

<b>REPORTING INFORMATION</b>																	
Hospital Name _____																	
Person completing this form (Name) _____																	
Designation _____																	
Date form completed _____ (DD/MM/YYYY)																	
<b>PATIENT IDENTIFICATION</b>																	
SNBTS issue code	<b>Named Patient Basis use</b>	Patient hospital/id number _____															
Patient's Initials _____	Patient Sex	M <input type="checkbox"/>	F <input type="checkbox"/>														
Date of birth _____ (DD/MM/YYYY)																	
<b>TREATMENT INFORMATION</b>																	
Date of CTL treatment	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td align="center">Day</td><td align="center">Month</td><td align="center">Year</td><td></td></tr></table>					Day	Month	Year		Time of treatment	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td align="center" colspan="3">24 hour</td></tr></table>				24 hour		
Day	Month	Year															
24 hour																	
Batch No _____																	
<b>DETAILS OF EVENT / REACTION</b>																	
Please record the diagnosis or describe the event in as few words as possible: _____																	
Date event/reaction started	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td align="center">Day</td><td align="center">Month</td><td align="center">Year</td><td></td></tr></table>					Day	Month	Year		Time event/reaction started	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td align="center" colspan="3">24 hour</td></tr></table>				24 hour		
Day	Month	Year															
24 hour																	
Date event/reaction resolved	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td align="center">Day</td><td align="center">Month</td><td align="center">Year</td><td></td></tr></table>					Day	Month	Year		Time event/reaction resolved	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td align="center" colspan="3">24 hour</td></tr></table>				24 hour		
Day	Month	Year															
24 hour																	
Outcome																	
Recovered	<input type="checkbox"/>	Recovering	<input type="checkbox"/>														
Continuing	<input type="checkbox"/>	Patient Died	<input type="checkbox"/>														
Outcome Unknown	<input type="checkbox"/>																
Are there any clinical sequelae? Yes <input type="checkbox"/> No <input type="checkbox"/>																	
If yes, please describe: _____																	
Is the event related to the CTL treatment ?																	
Probably	<input type="checkbox"/>	Possibly	<input type="checkbox"/>														
Unrelated	<input type="checkbox"/>																
<b>TREATMENT REQUIRED</b> (please give details on next page)																	
None <input type="checkbox"/>																	



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Specific drug therapy      Yes       No

if yes, list all drugs used:

Drug (Brand, if known)	Daily dose/route of admin	Date started	Time started							
_____	_____	<table border="1" style="display:inline-table; border-collapse: collapse;"> <tr><td style="width:10px; height:15px;"></td><td style="width:10px; height:15px;"></td><td style="width:10px; height:15px;"></td><td style="width:10px; height:15px;"></td></tr> </table> Day    Month    Year					<table border="1" style="display:inline-table; border-collapse: collapse;"> <tr><td style="width:10px; height:15px;"></td><td style="width:10px; height:15px;"></td><td style="width:10px; height:15px;"></td></tr> </table> 24hour			
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Other treatment      Yes      No  
If yes, please describe

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**CONCOMITANT MEDICATION**

List other generic drugs being given:-

Generic Name	Dosage regimen	Route	Date Started	Time Started							
_____	_____	_____	<table border="1" style="display:inline-table; border-collapse: collapse;"> <tr><td style="width:10px; height:15px;"></td><td style="width:10px; height:15px;"></td><td style="width:10px; height:15px;"></td><td style="width:10px; height:15px;"></td></tr> </table> Day    Month    Year					<table border="1" style="display:inline-table; border-collapse: collapse;"> <tr><td style="width:10px; height:15px;"></td><td style="width:10px; height:15px;"></td><td style="width:10px; height:15px;"></td></tr> </table> 24 hour			
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ADDITIONAL RELEVANT INFORMATION (e.g. test results etc)

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**Clinician review and approval of content**

signed \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

Please scan completed pages and e-mail to [nss.ctlbank@nhs.net](mailto:nss.ctlbank@nhs.net) (or fax to 0131 314 5799).