SUPPLEMENTAL PHYSICIAN REQUEST FORM FOR CONVALESCENT PLASMA FOR COVID-19

Please complete all required information & return this form to your Transfusion Services/ Blood Bank

Hospital Name: _____

Patient Name: _____ DOB: ___/___/_____
(Last, First) *MM / DD / YYYY*

Gender: _____ MRN: _____ # of Days in ICU: _____

Date of Disease Onset: ___/___/_____ Date of POSITIVE COVID-19 test result: ___/___/_____
MM / DD / YYYY *MM / DD / YYYY*

Date of Admission: ___/___/_____ Ordering Physician Name: _____
MM / DD / YYYY

Date Ordered: ___/___/_____ Time Ordered: _____
MM / DD / YYYY *(24hr)*

Based on Mayo IND Protocol & Coalition Consensus Criteria	
Duration *Check 1 or 2 for duration*	
1	☐ ≤7 days since start of symptoms
2	☐ ≥8 days since start of symptoms
Severity Class *Check all symptoms that apply*	
a	Rapidly progressive disease ☐ e.g., increasing O2 need over past 12 hours
b	Severe disease ☐ Dyspnea ☐ Respiratory Frequency ≥ 30/min ☐ Blood O2 Saturation ≤ 93% ☐ Partial Pressure of Arterial O2 to Fraction of Inspired O2 Ratio < 300 ☐ Lung Infiltrates > 50% within 24 - 48 hours
c	Critical disease (Life Threatening Disease) ☐ Respiratory Failure ☐ Septic Shock ☐ Multiple Organ Dysfunction or Failure
Summary Patient Severity Score 1a 1b 1c 2a 2b 2c *(Circle One)*	

Does patient shows signs or symptoms of rapid disease progression over last 24 hours? Y / N

If Yes, describe: _____

Date of Planned Transfusion: ___/___/_____
MM / DD / YYYY

For Hospital Blood Bank Use only:

Patient ABO/Rh: _____ # of Units Requested: 1 or 2
(Circle One)