



Rotary Blood Bank Gurgaon

(An ISO 9001: 2015 Certified Blood Bank)



FORM FOR NOMINATION OF NODAL OFFICER BY MS/DMS FOR REQUISITIONING CONVALESCENT PLASMA FROM ROTARY BLOOD BANK GURGAON

1. Name of Hospital proposing to use COPLA for COVID Patients:
2. Address:
3. Name of Medical Superintendent/ Operational Head:
4. Name and Designation of Nodal Officer designated for requisition of COPLA:
5. Contact Number:
6. Agreement Terms and Conditions:

TERMS AND CONDITIONS OF ISSUE OF CONVALESCENT PLASMA

1. I /We hereby notify the above mentioned **Nodal Person** to co-ordinate and requisition COVID-19 Convalescent Plasma from Rotary Blood Bank Gurgaon.
2. I/We agree that COVID-19 Convalescent Plasma will be issued only on the request/Prescription of the Treating Physician, no Patient / Attendant shall solicit Plasma for their Patient without valid Prescription.
3. I/We agree that the requisition of Plasma along with Blood Sample for Grouping and Cross-Matching would be checked and verified by the Physician and it would be their responsibility to check the plasma received from the Plasma Bank, before usage in the Patient.
4. I/We agree that the ICMR Guidelines (Version 4, 27.06.2020) and DCGI Guidelines (01.07.2020) shall be followed at present. However, the prevailing guidelines shall be followed as and when updated by ICMR for issuance of the Plasma.
5. I /We agree that it shall be the responsibility of the Treating Physician /Nodal Officer wrt:-
 - a. Requisition Form and Blood Sample is sent as per legal requirements to Rotary Blood Bank Gurgaon.
 - b. All information requested on the Patient Information Sheet is filled and duly signed by the Treating Physician, and countersigned by the Nodal Officer of the concerned Hospital.
 - c. Transfusion Follow-up and Treatment outcome is reported to Nodal Officer Civil Hospital Gurgaon in the designated format as early as possible.
6. I / We agree that the COVID-19 Convalescent Plasma shall be used only for **off label** use on a compassionate basis as per ICMR Guidelines (Version4, 27.6.2020) and DCGI Guidelines (01.07.2020) and not as a part of any Clinical Trial. (Off-label use means, Physicians can use an approved therapy for an as yet unapproved indication).
7. I / We agree that outcomes of use of this COVID-19 Convalescent Plasma will not be used for any Academic Presentation or Publication without prior permission of the Govt. of Haryana and/or CMO Gurgaon.



Rotary Blood Bank Gurgaon

(An ISO 9001: 2015 Certified Blood Bank)



8. I / We agree that if the above conditions are not met, further COVID-19 Convalescent Plasma will not be issued to us.
9. I / We shall be entirely responsible for the correct selection of the Patients, Plasma Infusion, monitoring of the Patients, management of Adverse Events and the Outcomes, including Mortality.
10. I / We would keep a Record of all the patients, as per the Guidelines.
11. Neither the Govt. of Haryana nor Rotary Blood Bank Gurgaon would be directly or indirectly, legally and/or financially liable for outcomes of the off-label use of Plasma Therapy.
12. I / We agree that charges as applicable, shall be payable at Rotary Blood Bank Gurgaon Billing Desk at the time of issuance of Plasma. Attendants/ family of Patient shall be adequately counselled regarding the same before sending for issuance of Plasma.

I, _____, Medical Superintendent / Operational Head, _____ Hospital do

hereby declare that I have read and understood the conditions mentioned above and agree to abide by the same for the purpose of COVID Convalescent Plasma Use in my Hospital.

Name and Signature of Medical Superintendent

Seal

Date:

Place:

Specimen Signature of Nodal Officer

Signature & Stamp:

Name:

Designation:

Contact number:

Email:

Authorized By Medical Superintendent

Signature & Stamp:

Name:

Designation:

Contact Number:

Email: