Autologous Serum Eyedrops - Request Form

Information for referring ophthalmologists

Arranging Autologous Serum Eyedrops (AutoSEDs)

Before being referred for Autologous Serum Eyedrops, patients must be advised of the risks and benefits of autologous blood collection and AutoSEDs. They should have a clear understanding of why they are being referred for autologous blood collection for the manufacture of AutoSEDs. A patient information brochure is available on transfusion.com.au for the referring ophthalmologist to discuss with their patient.

To refer a patient for Autologous Serum Eyedrops by Lifeblood, the referring ophthalmologist must complete this form and fax or email the request form to Lifeblood as below. Lifeblood may contact the patient to clarify medical history, and where the request is accepted, the patient will be contacted to make an appointment for blood donation.

If you require further information please contact our Lifeblood Medical Officer.

Important considerations

- Lifeblood will collect autologous whole blood for the manufacture of AutoSEDs from those patients who have failed other therapies for the treatment of severe dry eye syndrome. according to the Guidelines developed by the UK Royal College of Ophthalmologists (2017)
- In order for Lifeblood to manufacture Autologous Serum Eyedrops, your patient will need to meet the above guidelines and also be eligible to donate blood at a Lifeblood donor centre. Lifeblood will assess their eligibility to donate, according to the Guidelines for the Selection of Blood Donors (GSBD). If it is considered acceptable to proceed, up to 470mL of blood will be collected at a Lifeblood Donor Centre.
- Lifeblood only processes autologous blood collections for AutoSED from donors aged 16 – 80 years. Blood collection can result in syncopal reactions, which may be harmful in certain medical conditions. To find out more information regarding eligibility, contact the Medical Services team at Lifeblood as below and ask to speak to a Lifeblood Medical Officer.
- A key consideration for donation eligibility is Haemoglobin level with the acceptable donation ranges being: Females – 120-165 g/L; Males – 130-185 g/L. Contact a Lifeblood Medical Officer to discuss options should your patient be outside the acceptable ranges.
- On the day of collection, the patient will be required to fill out a donor questionnaire form and if eligible, blood will be collected and sample tubes will be taken. All autologous blood is tested for HIV, hepatitis B, hepatitis C and syphilis. New donors are also tested for HTLV. Blood confirmed as positive for a viral marker is discarded and AutoSEDs will not be manufactured.
- The referring ophthalmologist is responsible for arranging for an Approved Health Provider (AHP) or Hospital Laboratory to receive delivery of and store the AutoSEDs until the patient can arrange pick up. Lifeblood can assist with providing a list of AHPs who have the capacity to receive and store AutoSEDs.
- Lifeblood will contact the patient when the AutoSEDs are ready for collection from the specified AHP or Hospital Laboratory.
- The referring ophthalmologist is responsible for explaining the directions of use and the storage requirements of AutoSEDs, including the requirement for sufficient storage space for the AutoSEDs in a domestic freezer at the patient's home.

Privacy Statement: The personal information collected on this form allows the referred patient to be registered and retained as an autologous blood donor. All information collected will be handled in the strictest confidence in accordance with the Federal Privacy Law.

This request form is for Autologous Serum Eyedrops only.

For Autologous (Red Cell) Blood, use *Pre-operative Autologous Blood Request Form* (FRM-00564).

This Autologous Serum Eyedrops Request Form is to be faxed or emailed to Lifeblood, and a copy given to the patient for their reference.

FAX FORM TO: 07 3838 9421

OR EMAIL TO: medicalservicesadmingld@redcrossblood.org.au

FOR INFORMATION, CONTACT: 1300 669 054

Ophthalmologist's request

To be completed and signed by the primary consultant ophthalmologist or another doctor involved in the patient's care acting on behalf of the ophthalmologist.

Section 1: Patient Details

Patient name:	**DOB:**
Address:	
Home phone:	**Work phone:**
Mobile phone:	**Email address:**
Name or AHP code of clinic / hospital laboratory preferred for delivery:	

Is this an Initial Request for this patient?

☐ **Yes:** Please complete Section 2

☐ **No:** Please complete Section 2 and 3

Section 2: Clinical Indication for AutoSED therapy

The patient has failed conventional therapies at maximum tolerated doses and has ongoing symptoms of moderate to severe dry eye based on clinical assessment by an ophthalmologist

☐ Yes ☐ No

Clinical indication for Severe Dry Eye Syndrome (please tick one):

☐ Sjögren's Syndrome related dry eye,

☐ Ocular Mucous Membrane Pemphigoid,

☐ Stevens-Johnson-Syndrome/Toxic Epidermal Necrolysis

☐ Graft Versus Host Disease,

☐ Ulcerative keratitis,

☐ Neurotrophic cornea such as Diabetic cornea, Herpetic aetiology, Other neuropathic disease including secondary to non-ocular, extra-ocular and neuro surgery.

☐ Acute management of corneal injury (mechanical, chemical, thermal, surgery)

☐ Supportive such as Ocular surface reconstruction, Corneal transplantation, Other supportive e.g. critical care unit/high dependency/burns unit

☐ Inherited Ocular Surface Disease

☐ Other (please describe below)

_____

Section 3: Response to AutoSED therapy (Please tick all that apply)

☐ Symptomatic improvement

☐ Objective improvement with tests (please tick)

- ☐ Ocular Surface Disease Index (OSDI) score
- ☐ Tear break-up time
- ☐ Schirmer test

☐ No improvement

☐ Other (please describe below):

_____

Section 4: Patient Medical History (completed by the referring ophthalmologist)

All responses will be reviewed by a Lifeblood Medical Officer, who may contact the treating ophthalmologist, or the patient for further information.

Height		**Weight**	

For questions answered with 'Yes', provide additional details below. Has the patient ever had?

Peripheral or cerebrovascular disease?	☐Yes ☐ No
Coronary artery disease?	☐Yes ☐ No
Diabetes?	☐Yes ☐ No
Anaemia or iron deficiency?	☐Yes ☐ No
Other chronic medical conditions?	☐Yes ☐ No
A bone marrow transplant (if yes please provide month/year)?	☐Yes ☐ No
A positive test result for hepatitis B, hepatitis C or HIV?	☐Yes ☐ No

Additional Details:

Please list all current medications:

Section 5: Declaration by Ophthalmologist

- I confirm that I have reviewed this patient and that they qualify for therapy with AutoSEDs in accordance with the Guidelines of the UK Royal College of Ophthalmologists (2017). I request that Lifeblood collect blood from my patient for the manufacture of AutoSEDs.
- I accept that my patient's fitness for autologous blood collection is at the discretion of Lifeblood.
- I confirm that my patient is between their 16th and 81st birthday.
- I have discussed the risks and benefits, the directions for use and the storage requirements of AutoSEDs, including the need for a domestic freezer at the patient's home with my patient and/or my patient's parent or legal guardian.

Print Referring Ophthalmologist Name:	**Provider number:**
Signature:	**Date:**
Postal Address:	**Phone & fax:**
Email Address:	

Section 6: Internal Use Only *To be completed by a Lifeblood Medical Officer*	
Is the patient eligible for AutoSED	☐ Yes ☐ No ☐ No - PT SED (*Note: AO to forward documents to regional TM Specialist)*
Reason if not eligible:	
Assessed by (Medical Officer):	**Date:**