COVID-19 PLASMA COLLECTION

The Chicago Medical Society is seeking blood donations from individuals who have recovered from coronavirus to help in the treatment of COVID-19 patients. This document describes the Chicago Medical Society's efforts with respect to blood collection. To the extent your hospital does not already have a protocol for the collection of blood for convalescent plasma treatment of COVID-19, this document also contains a set of eligibility criteria for potential donors.

Convalescent Plasma: What is it and how do patients benefit?

Individuals who have completely recovered from COVID-19 may have certain antibodies in their plasma, known as "convalescent plasma," that can be used to treat individuals with serious or life threatening COVID-19 infections.

The Food and Drug Administration has recently approved the transfusion of convalescent plasma as an investigational treatment for COVID-19 infections. This is currently the only antibody treatment available for COVID-19 patients.

Who is eligible to donate convalescent plasma?

In order to donate blood for the study of convalescent plasma as a COVID-19 treatment, individuals must meet the following criteria:

- Documentation of SARS-CoV-2 infection (diagnosis and recovery) as follows:
    - A diagnostic test (e.g., nasopharyngeal swab) taken at the time of illness, or
    - A positive serological test for SARS-CoV-2 antibodies after recovery, if prior diagnostic testing was not performed at the time COVID-19 was suspected. Written documentation may be hand carried by the prospective donor.
- Recovery of donor:
    - Complete resolution of symptoms at least 28 days prior to donation; or
    - Complete resolution of symptoms at least 14 days prior to donation, AND negative results for COVID-19 either from one or more nasopharyngeal swab specimens or molecular diagnostic test from blood; or
    - Symptom free less than 14 days AND negative test results on different days (collection may not have peak antibody levels).

What documentation is required in order to donate blood?

The donor must have documentation demonstrating that he/she meets the eligibility criteria, including written documentation of a COVID-19 infection. The donor must also complete the HIPAA Authorization attached to this document, which will allow for the disclosure of protected health information to the Chicago Medical Society and other hospitals, facilities, researchers, and physicians involved in the treatment of COVID-19 patients or the study of convalescent plasma therapy for COVID-19 treatment.

HIPAA Authorization

Authorization for Use or Disclosure of Protected Health Information under the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164

I _____ (print name), hereby authorize _____(healthcare provider) to disclose my protected health information (PHI) to Metro Infectious Disease Consultants and other hospitals, facilities, researchers, and physicians involved in the treatment of COVID-19 patients or the study of convalescent plasma therapy, for the purposes of studying and researching the use of convalescent plasma in the treatment of COVID-19.

This HIPAA Authorization shall be in force and effect until _____ (date or event), at which time this HIPAA Authorization will expire.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

I understand that signing this HIPAA Authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

I understand that information used or disclosed pursuant to this HIPAA Authorization may be disclosed by the Chicago Medical Society or other hospitals, facilities, researchers and physicians and may no longer be protected by federal or state law.

_____
Patient name (print)

_____
Signature

_____
Date

If not patient, name of person signing form:
_____

Authority to sign on behalf of patient:

_____