Prospective Observational Patient Safety Registry Study on Human Autologous Adipose-Derived Mesenchymal Stem Cells Infusion and Injection

Case Report Form Supplement

PHYSICIAN CONSULTATION FORM

Required

Patient Full Name	Gender	Date of Birth (MON/dd/yyyy)	Survey Date (MON/dd/yyyy)
	☐ Male ☐ Female		

INSTRUCTIONS: This physician consultation form is designed to be completed by a physician especially for clients who are interested in stem cell therapy. This form supplements our other surveys, and must be completed in combination with the Con Med form and the Client Information Form. This form provides Celltex Therapeutics Corporation with the demographic information necessary to create a baseline to track the efficacy of stem cell therapy.

Name of person completing this survey	NPI number	Phone number	Email Address

I. PHYSICAL EXAM

Exam date _____

Diagnosis _____

Height _____ Weight _____

BP (sys / dya) _____ Heart rate (pulse) _____

Respirations _____ Temperature _____

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Physical evaluation

	Normal	Abnormal	Not Assessed	Remarks
General appearance	☐	☐	☐	
HEENT	☐	☐	☐	
Neck	☐	☐	☐	
Lymph nodes/ endocrine	☐	☐	☐	
Skin	☐	☐	☐	
Lungs	☐	☐	☐	
Heart	☐	☐	☐	
Abdomen	☐	☐	☐	
Neurological	☐	☐	☐	
Musculoskeletal	☐	☐	☐	
Gastrointestinal	☐	☐	☐	
Psychological	☐	☐	☐	

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Physician's notes

Request lab/ Image tests

1. _____
2. _____
3. _____

Physician signature: _____

Date: _____

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II. RECOMMENDATIONS FOR STEM CELL (MSC) THERAPY

Recommend autologous stem cell (MSC) therapy: ☐ Yes ☐ No

Dose regiment:

Duration: _____

Frequency: _____

Recommended route of administration and dosage (check all that apply):

OSTEOARTHRITIS RECOMMENDED TREATMENT PROTOCOLS:

☐ OPTION 1:

- 2 x IV (intravenous; approximately 200 million MSCs)
- IA (intra-articular; approximately 100 million MSCs)
- Specify locations for IA injection: _____

☐ OPTION 2:

- 1 x IV (intravenous; approximately 200 million MSCs)
- IA (intra-articular; approximately 100 million MSCs)
- Specify locations for IA injection: _____

☐ OTHER (please specify dosage and quantity in section below):

NEURODEGENERATIVE RECOMMENDED TREATMENT PROTOCOLS:

☐ OPTION 1:

- 2 x IV (intravenous; approximately 200 million MSCs)
- IT (intrathecal; approximately 100 million MSCs)
- IL (intra-lymphatic; approximately 100 million MSCs)
- IN (intra-nasal: approximately 100 million MSCs)

☐ OTHER (please specify dosage and quantity in section below):

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AUTOIMMUNE and INFLAMMATION RECOMMENDED TREATMENT PROTOCOLS:

☐ OPTION 1:

- 3 x IV (intravenous; approximately 200 million MSCs)
- IL (intra-lymphatic; approximately 100 million MSCs)

☐ OPTION 2:

- 2 x IV (intravenous; approximately 200 million MSCs)
- 1 x IV (intravenous; approximately 100 million MSCs)
- IL (intra-lymphatic; approximately 100 million MSCs)
- IN (intra-nasal: approximately 100 million MSCs)

OPTION 3:

- 3 x IV (intravenous; approximately 200 million MSCs)

☐ OTHER (please specify dosage and quantity in section below):

NEURO-AUTOIMMUNE RECOMMENDED TREATMENT PROTOCOLS:

☐ OPTION 1:

- 3 x IV (intravenous; approximately 200 million MSCs)
- IL (intra-lymphatic; approximately 100 million MSCs)
- IT (intrathecal; approximately 100 million MSCs)
- IN (intra-nasal: approximately 100 million MSCs)

☐ OPTION 2:

- 2 x IV (intravenous; approximately 200 million MSCs)
- IL (intra-lymphatic; approximately 100 million MSCs)
- IT (intrathecal; approximately 100 million MSCs)
- IN (intra-nasal: approximately 100 million MSCs)

☐ OPTION 3:

- 2 x IV (intravenous; approximately 200 million MSCs)
- 2 x IL (intra-lymphatic; approximately 100 million MSCs)
- IN (intra-nasal: approximately 100 million MSCs)

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☐ OTHER (please specify dosage and quantity in section below):

ANTI-AGING/WELLNESS RECOMMENDED TREATMENT PROTOCOLS:

☐ OPTION 1:

- 2 x IV (intravenous; approximately 200 million MSCs, 3 days interval, repeated every 12 months)
- IN (intra-nasal: approximately 100 million MSCs)

☐ OPTION 2:

- 3 x IV (intravenous; approximately 200 million MSCs, 3 days interval, repeated 2 IV every 12 months)
- IN (intra-nasal: approximately 100 million MSCs)

☐ OTHERS:

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OTHER TREATMENT RECOMMENDATIONS:

☐ IV (intravenous)
Specify dosage of IV (options 100m or 200m MSCs): _____
Specify number of recommended IV treatments: _____
Specify frequency of recommended IV treatments: _____

☐ IT (intrathecal)
Specify dosage of IT (options 100m or 50m MSCs): _____
Specify number of recommended IT treatments: _____
Specify frequency of recommended IT treatments: _____

☐ IA (intra-articular)
Specify dosage of IA injections (options 100m or 50m MSCs): _____
Specify number of recommended IA injections: _____
Specify locations for IA injection: _____
Specify frequency of recommended IA injections: _____

☐ IL (intra-lymphatic)
Specify dosage of IL (options 100m or 50m MSCs): _____
Specify number of recommended IL treatments: _____
Specify frequency of recommended IL treatments: _____

☐ IN (intra-Nasal)
Specify dosage of IN (options 100m or 50m MSCs): _____
Specify number of recommended IN treatments: _____
Specify frequency of recommended IN treatments: _____

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Physician's notes: Please provide additional comments or direction regarding frequency or number of treatments recommended.

Physician's expectation of recovery after MSC therapy:

☐ Significant/ noted improvement ☐ Some improvement ☐ None

Physician's notes: Please provide your opinion regarding expected outcomes for this patient given current medical models and standards of therapies. Include references if desired.

Physician Signature: _____

Date: _____

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