

Request for Storage/Processing of Autologous Tissue

Patient Information	Patient Name			Graft Description:
	Patient Date of Birth		Age:	Sex: <input type="checkbox"/> F <input type="checkbox"/> M
	Medical Record # or SSN			Recovery Date:

				Recovery Time (Military time) :
				Packaged By:
				Packaged Date:
				Packaged Time (Military time) :

Physician /Facility Information	Name of Physician			Physician Phone #:	
	Name of Facility				
	Street Address				
	City, State Zip				
	Name of Surgical Contact			Contact Phone #	

Instructions	<input type="checkbox"/> Storage <input type="checkbox"/> Irradiate <input type="checkbox"/> Other			
	Special Instructions/Comments: (Storage conditions, etc.)			

CONSENT AND RELEASE:

I hereby give permission for Community Tissue Services (CTS) to store this autologous tissue. I understand that CTS will store this tissue for up to a period of one year, unless otherwise notified in writing. If I request CTS to store the tissue longer than one year, I understand that the tissue cannot be stored longer than five years total.

I understand that if the tissue is not suitable for implant, or if CTS receives no written notification regarding continued storage of the tissue, the tissue will be treated and disposed of according to state and local regulations.

This patient, to the best of my knowledge, does not have bacteremia, or other significant bacterial infections, including sepsis, and/or does not have or is at high risk for other infectious diseases such as hepatitis and/or HIV.

In consideration for CTS performing the services described herein, I hereby release CTS, its trustees, officers, employees, agents, or other representations and affiliates from any and all liability for claims, losses, and/or expenses which I or my heirs and other legal representatives might ever have resulting directly or indirectly from the tissue and not being suitable for implant due to an Accident and/or Failure or the tissue not being viable upon implant.

By signing this consent, I take responsibility for ensuring the consent for donation was/will be obtained from the donor/patient in compliance with state/federal laws and the applicable hospital consent form.

Physician's Signature

Date

(To be completed by CTS)

CTS Autologous Donor Number	
Tissue Expiration Date	

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Applies To:	All CTS Branches (Both Recovery and Distribution); MFG; QRA-QC; CTS Website
Review/Approval Requirements:	COO-Tissue Services; Executive Director (Recovery); QRA

REVISION TRACKING			
Rev #	Explanation of Changes <i>(include what changed including reason, when applicable)</i>	Change Initiated By	Implementation Date
Rev 00	Formerly TB Form #81	H. Moore	5-27-11
Rev 01	FILE ONLY - Added CTSPEN to Applies To section. See NCR SM-018-13.	L. Carolus	6-28-13
Rev 02	Formerly TR-701-F-02. Changed number for Autologous series to incorporate all departments involved. Updated Instructions box and revised the Patient information box. Added CTSPB and CTSPM to Applies To section.	NJ/AY/HRM /PJS	8-22-14
Rev 03	Added CTS-Website to Applies To section.	PJS	9-26-14

VERSION TRACKING				
Version #	Explanation of Changes <i>(Describe and justify the change)</i>	Type of Training Needed <i>(File Only OR Review Document OR Review and Training)</i>	Change Initiated By	Implementation Date
1.0	Initial upload to SharePoint	Review and Training	eSOP Team	4-13-15
2.0	Per CO150065 (no longer processing parathyroids): Removed "cryopreserve" as a processing instruction; removed antibiotic allergy question in "instructions" section; It is acceptable for hospitals to exhaust supply of Rev 03 of this form before switching to V 2.0, as all customers have been notified that CTS will no longer process parathyroids, so no parathyroids have been received in over 6 months. Updated "Applies to" section to "All CTS Branches..." instead of listing out individual branches. Reformatted boxes for "Recovery date/time" and "Packaged by/date/time" so they are separate fields.	Review Document	K. Patrick	8-21-15