**Autologous Cranial Bone Flap Release for Transfer to Outside Facility Form**

TO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of Facility Requesting Transfer)

This form validates a request from the above named facility for autologous cranial bone flap to be transferred from Harborview Medical Center (HMC) to the requesting facility. Transfer of autologous bone will occur for patients originally treated for traumatic injuries at HMC and subsequently scheduled for re-implantation/cranioplasty of autologous cranial bone flap at the receiving facility.

Autologous Cranial Bone Flap Tissue will be released from HMC for transport by an authorized courier of the requesting facility. The courier will present the form to HMC Transfusion Services to identify the tissue for transfer and provide a tissue tracking document. Verification of patient and bone identification criteria precedes transfer of tissue.

*(Please Print)*

Date bone transferred to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requested by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  *Surgeon Operating Room RN*

Contact phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name of recipient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Medical Record Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HMC MRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Recipient Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M F

A two person verification of all 4 identification criteria completed between:

□Patient name □Medical Record Number □HMC Number □ Date of Birth

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***Requesting Facility COURIER*** ***HMC Transfusion Services***

 **Delivered by Requesting Facility Staff to Operating Room RN or designee**

 Date Bone received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A two person verification of all 4 identification criteria completed between:

□Patient name □Medical Record Number □HMC Number □ Date of Birth

□Package integrity intact □Temperature criteria met □Placed in Freezer □Logged

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***Requesting Facility COURIER*** ***Receiving Nurse or Designee***