**NOTIFICATION FOR USE/RELEASE OF AUTOLOGOUS CRANIAL BONE FROM A NON-CONFORMING PRODUCT FORM**

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospital ID Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Bone Flap Unique Product Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am the physician of record for the above autologous bone flap recipient. I understand that the above product which I am requesting to be stored / issued *(circle as appropriate)* is non-conforming for the following reason(s) *(check all that apply):*

□ Results of 7 day microbial product cultures are still pending.

□ Product does not meet Transfusion Services Laboratory pre-established acceptability criteria:

*(Please specify)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Comments:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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After review of the above statement, reviewing the relevant documentation and discussion of these results and the risks, benefits and alternatives to reimplanting this bone with the recipient, the recipient and I elect to: *(please check)*

□ Use this product

□ Decline using this product

□ Discard the product

**Recipients Physician:** *(Name)*  .

*(Signature)* *(Date)*  .

*(Date)*  .**Chief of Neurosurgery (or designee):** *(Signature)*

*(Date)*  .**Transfusion Services Laboratory Physician:** *(Signature)*

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