**NOTIFICATION FOR RELEASE OF A NON-CONFORMING AUTOLOGOUS TISSUE FORM**

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

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

As the physician for the above autologous tissue recipient, I understand that the autologous tissue is non-conforming for the following reason(s) *(check all that apply):*

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

🞎 Results of 7 day microbial product cultures are positive

🞎 Product does not meet Transfusion Services Laboratory pre-established acceptability criteria: *(please specify)*:

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

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After review of the above statement, reviewing the relevant documentation and discussion with the recipient regarding reimplantation of this tissue, I elect to:

🞎 Use this product

🞎 Decline using this product, please discard.

**Recipient’s Attending Physician (or designee):** *(Signature)*.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***(Date)*** \_\_\_\_\_\_\_\_\_\_\_\_

**Recipient’s Attending Physician (or designee):** (*Printed name*)

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

C-F5004, *Version 3.0 July 2016*