|  |
| --- |
| **Tissue Identification Number:** |
| **Patient Name:** | **MRN:** |
| **Collection Date/Time:** | **Notification Date/Time:** |

**Reason for Discard** *(check any that apply)*

* Exceeds the 12 (Non-Cranial) or 24 month (Cranial) storage limitations.
* Patient Expired *(See attached death notification)*
	+ **NOTE:** In case the patient’s family were to request the product, it will be quarantined for a

minimum of two weeks.

* Positive Culture results
* Autograft Skin is not acceptable for storage due to any of the following
* Expired Skin
* Out of monitored temperature
* Other: **\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHYSICIAN ONLY:**

I acknowledge receipt of notification that the autologous bone for this patient will be discarded.

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*Attending Physician Signature* *Date*

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

*Attending Physician Print* *Date*

(Type Physician’s name here prior to mailing form)

**TRANSFUSION SERVICE USE ONLY:**

Autologous Tissue approved to be discarded.

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*Medical Director* *Date*

Discard Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tech ID/Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Verified by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *(TSL Tech ID / Date)*