**Notification of Intent to Transfer Autologous Bone to**

 **Harborview Medical Center – Transfusion Services Laboratory**

FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Name of Facility Requesting Transfer of Autologous Bone Tissue)

This form initiates a request from the above named facility for transfer and subsequent temporary storage of an autologous bone tissue in the Ultra-Low (-80) freezer at Harborview Medical Center – Transfusion Services Laboratory.

The requesting facility’s courier will present this form to HMC Transfusion Services to identify the tissue being transferred and provide a tissue tracking document. Two-person verification of patient and bone identification criteria precedes transfer of tissue.

***Please complete form and fax back to HMC-Transfusion Services Lab (206)744-6530 to initiate Request for transfer.***

***Please indicate if a Validated Transport Box is NEEDED :  YES*  NO**

**Date and time of transfer**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

  *Surgeon Operating Room RN*

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

**Patient’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**UWMC MRN**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HMC MRN (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

***This part is to be completed at the time of receipt of bone flap at***

***Harborview Medical Center-Transfusion Services Laboratory***

A two person verification check is completed at time of transfer

□ Patient name □ UWMC MRN □ HMC MRN □ Date of Birth

 Package integrity verified

 Temperature upon receipt \_\_\_\_\_°C  Thermometer ID# \_\_\_\_\_

 Container and contents:  Satisfactory  Unsatisfactory

Requesting Facility Designee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date and time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HMC TSL Tech: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date and time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_