This form must accompany autologous bone to surgery and be completed and returned to Harborview Medical Center after the autologous bone is used or discarded.  Please provide all requested information.  It is important for our follow-up records.

**Please print**

Final Disposition □ Transplanted □ Discarded Date of Transplant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Medical Record Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_ Gender: M F

Surgeon Transplanting Bone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last, First

Surgeon’s Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Form Completed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Completion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TO BE COMPLETED BY HARBORVIEW:**

**PLACE BARCODE STICKER HERE**

Type of Bone to be transported: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Date Time Packaged Signature

I hereby certify that the above listed bone has been maintained within temperature ranges in accordance with Federal regulations. Bone package was inspected when packaged for this shipment and found to be in satisfactory condition.

Package integrity verified prior to packaging bone package in transport container. A two person verification “read-back” of the patient identification brought to HMC TSL against the bone package label was performed by the TSL tech issuing the bone package and a second TSL tech.

**Employee Initial/ID number:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employee Initial/ID number:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **TO BE COMPLETED BY RECEIVING FACILITY:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date Time Received Signature  **Temperature upon receipt \_\_\_\_\_\_\_\_\_\_°C. (Must be maintained at a temperature of ≤ - 40°C or colder.)**  **Container and contents 🞏 Satisfactory 🞏 Unsatisfactory**  **Shipping discrepancies must be reported to Harborview’s Transfusion Services (206-744-3088).** |

**RETURN FORM, CONTAINER THAT TISSUE TRANSPORTED IN, AND THERMOMETER TO:**

**HARBORVIEW MEDICAL CENTER**

C/O Transfusion Services Laboratory, 325 9th Ave. Mailbox 359735, Seattle, WA. 98104-2499