Community Tissue Services
Dayton, OH 45402

**AUTOLOGOUS DONOR**
**"FOR AUTOLOGOUS USE ONLY"**

Patient Name:_____Age:_____

Patient MR/ID#_____Sex:_____

Hospital: _____

# of Specimens in Package: ____ Specimen Type_____

**To Be Completed by CTS Only:**
Autologous Donor #:_____Exp:_____

**"NOT EVALUATED FOR INFECTIOUS SUBSTANCES"**
**TR-701-F-01 Rev 00**

This is an Example of the Label. The actual label will not print with a header or footer.

| | |
|---|---|
| **Applies To:** | **CTSC, CTSD, CTSI, CTSMST, CTSNWT, CTSP, CTST** |
| **Review/Approval Requirements:** | **COO Tissue Services, Q/RA Staff** |

## REVISION TRACKING

| Rev # | Explanation of Changes<br>*(include what changed including reason, when applicable)* | Change Initiated By | Implementation Date |
|---|---|---|---|
| Rev 00 | Formerly TB Form #284 | ES/AW | 11-12-10 |