Request for Storage/Processing of Autologous Tissue

Patient Information	Patient Name			Medical Record # or SSN	
	Patient Date of Birth		Age	Gender	☐ F ☐ M
	Graft Description			**Date/Time of Recovery** (Use Military Time)	

Physician /Facility Information	Name of Physician		Physician Phone #:	
	Name of Facility			
	Street Address			
	City, State Zip			
	Name of Surgical Contact		Contact Phone #	

Instructions	☐ Storage ☐ Cryopreserve ☐ Irradiate ☐ Other		PO# (If available to surgery staff)	
	Special Instructions/Comments: (Storage conditions, any known allergies to antibiotics, etc)			
	Tissue Packaged By/Date/Time (Use Military Time)		CTS Notified By/Date/Time (Use Military Time)	

CONSENT AND RELEASE:

I hereby give permission for Community Tissue Services (CTS) to store this autologous tissue. I understand that CTS will store this tissue for up to a period of one year, unless otherwise notified in writing. If I request CTS to store the tissue longer than one year, I understand that the tissue cannot be stored longer than five years total.

I understand that if the tissue is not suitable for implant, or if CTS receives no written notification regarding continued storage of the tissue, the tissue will be treated and disposed of according to state and local regulations.

This patient, to the best of my knowledge, does not have bacteremia, or other significant bacterial infections, including sepsis, and/or does not have or is at high risk for other infectious diseases such as hepatitis and/or HIV.

In consideration for CTS performing the services described herein, I hereby release CTS, it trustees, officers, employees, agents, or other representations and affiliates from any and all liability for claims, losses, and/or expenses which I or my heirs and other legal representatives might ever have resulting directly or indirectly from the tissue and not being suitable for implant due to an Accident and/or Failure or the tissue not being viable upon implant.

By signing this consent, I take responsibility for ensuring the consent for donation was/will be obtained from the donor/patient in compliance with state/federal laws and the applicable hospital consent form.

_____ _____

Physician's Signature Date

To be completed by CTS

CTS Autologous Donor Number	
Tissue Expiration Date	

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

REVISION TRACKING

Rev #	Explanation of Changes *(include what changed including reason, when applicable)*	Change Initiated By	Implementation Date
Rev 00	Formerly TB Form #81	H. Moore	5-27-11