Solvita
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 Solvita Only:
Autologous Donor #:_____Exp:_____

"NOT EVALUATED FOR INFECTIOUS SUBSTANCES"
CTS-600-F-01 Ver 2 Final Storage at -40ºC or colder

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