Request for Storage/Processing of Autologous Tissue

Patient Information	Patient Name			Graft Description:
	Patient Date of Birth		Age:	Sex: ☐ F ☐ M
	Medical Record # or SSN			**Recovery Date:**
				Recovery Time (Military time)**:**
				Packaged on Ice By:
				Packaged on Ice Date:
				Packaged on Ice Time (Military time)**:**

Physician /Facility Information	Name of Physician			
	Name of Facility			
	Name of Surgical Contact		Contact Phone #	

Instructions	☐ Storage ☐ Irradiate ☐ Other
	Special Instructions/Comments: (Storage conditions, etc.)

CONSENT AND RELEASE:

I hereby give permission for Solvita to store this autologous tissue. I understand that Solvita will store this tissue for up to a period of one year, unless otherwise notified in writing. If I request Solvita 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 Solvita 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 Solvita performing the services described herein, I hereby release Solvita, 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 Solvita)

Solvita Autologous Donor Number	
Tissue Expiration Date	