Versiti | Blood Center of Michigan
1036 Fuller Ave NE | Grand Rapids MI 49503
p 616.233.8598 f 616.233.8559 w versiti.org

Order to Release Cryopreserved Products

To be Completed by Clinical Program:

Patient Name: _____ Hospital ID: _____ DOB: _____

DIN(s): _____

REASON FOR RELEASE FOR DISPOSAL:

- ☐ Patient expired; Date of Death: _____
- ☐ Patient no longer transplant candidate
- ☐ Other: _____

REASON FOR RELEASE FOR TRANSFER:

- ☐ Transfer product(s) for transplant; Facility Name: _____
- ☐ Other: _____

I have determined the cryopreserved cells may be released as indicated.

_____	_____	_____
Print Name – Transplant Center Provider	Signature – Transplant Center Provider	Date

***Forward completed form and copy of consent/storage agreement to* CTL@versiti.org**

To be Completed by Cell Therapy Lab:

The patient's processing records and consent/storage agreement have been reviewed, and I approve release of the cryopreserved cells as indicated.

Product(s) may be maintained for quality control/training. ☐ Yes ☐ No ☐ NA

Product(s) may be utilized for research. ☐ Yes ☐ No ☐ NA

_____	_____	_____
Print Name – Versiti Michigan Medical Director	Signature – Versiti Michigan Medical Director	Date

FINAL DISPOSITION:

- ☐ Product(s) physically discarded
- ☐ Product(s) no longer for clinical use; Maintained for quality control/training/research
- ☐ Product(s) transferred (refer to accompanying documents)

Date/Initials _____ Second Check Date/Initials _____

Forward completed form to Clinical Program