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

versiti™

Declaration of Urgent Medical Need
Ineligible Donor

Affix Recipient Hospital Label or Complete:	**Affix Donor Hospital Label or Complete** ☐ NA
Name: ______________________	Name/GRID: ______________________
DOB: ______________________	DOB: ______________________ ☐ NA
MRN: ______________________	MRN: ______________________ ☐ NA

Donor testing and/or screening on this donor indicate that the donor may be at increased risk for transmission of a communicable disease agent to the recipient. This donor is thereby classified as ineligible according to the Food and Drug Administration (FDA) regulations for human tissue intended for transplantation.

The FDA does not prohibit use of a product from an ineligible donor but does require documentation that the transplant center physician has been notified of the results of the donor screening and testing.

This donor eligibility has been deemed ineligible for the following reason(s):

- ☐ Positive testing Test(s) ______________________
- ☐ Physical assessment ______________________
  ____
- ☐ Health history screening or medical record ______________________
  ____

Urgent medical need, as defined by the FDA, means that no comparable donor/product is available, and the recipient is likely to suffer death or serious morbidity without use of a product from this donor.

Based on the above documentation, I choose to:

☐ Accept a product from this donor ☐ Decline a product from this donor

______________________	______________________	__________
Transplant Physician print	Transplant Physician signature	Date

A physician has explained to me, in terms I have understood, the reasons I am considered an ineligible donor. I understand the risks and benefits of allowing or disallowing my donated product to be used. I choose to:

☐ Allow the use of my product ☐ Not allow the use of my product ☐ N/A (Autologous)

______________________	______________________	__________
Donor Name print	Donor signature	Date

My physician has explained to me, in terms that I have understood, the risks and benefits to me if I proceed to receive a product from an ineligible donor.

I understand that if I choose to accept this product, I will be monitored for signs and symptoms of infection. Depending on my condition, my physician may choose to give me antibiotics or other treatment as they deem appropriate. I agree to accept the product.

______________________	______________________	__________
Recipient or Legal Guardian signature	Relationship, if legal guardian	Date
	______________________	__________
	Versiti-MI Medical Director signature	Date

©Versiti – All Rights Reserved