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

Patient Name: _____ DOB: _____ Hospital ID: _____

Unit ID(s): _____

Reason for release

- ☐ Patient expired
- ☐ Patient no longer transplant candidate
- ☐ Patient recovered
- ☐ Other _____

Consent for disposal obtained from patient/guardian

- ☐ At time of collection
- ☐ Post collection
- ☐ Efforts to contact patient/guardian have failed

Disposition

- ☐ Discard or utilize for QC/training/validation
- ☐ Transfer to _____

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

_____	_____	_____
Print Name – Transplant Center Physician	Signature – Transplant Center Physician	Date
_____	_____	_____
Print Name – Versiti Michigan Medical Director	Signature – Versiti Michigan Medical Director	Date

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Product Removal

Unit ID(s) _____

- ☐ Disposed: Box # _____ Date/Initials _____
- ☐ Transferred to _____ Date/Initials _____

Second Check Date/Initials _____