



Allogeneic Donor Eligibility Determination

Versiti Staff- Place Unit ID
here on day of collection

Instructions: The requesting Transplant Center is responsible for completing all fields of this form. The Versiti physician is responsible for approving authorization to collect an ineligible or incomplete allogeneic donor.

Donor Information	Recipient Information
<i>Apply Hospital Label for Donor or complete:</i> Name: _____ D.O.B.: _____ Medical Record #: _____	<i>Apply Hospital Label for Recipient or complete:</i> Name: _____ D.O.B.: _____ Medical Record #: _____

Donor Eligibility Determination

Date Infectious Disease Testing was performed at CLIA certified laboratory: _____

Date of Donor History & Physical: _____

Date Donor History Questionnaire was completed: _____

Donor's eligibility has been determined by the requesting transplant center program based on criteria specified in 21 CFR Part 1271. After review of the testing, screening, and medical record, this donor is deemed to be:

- Eligible
 - *Ineligible for the following reason(s):**
 - Communicable Disease risk based on donor screening (medical history, physical assessment)
List Reason(s): _____
 - Reactive Test Results. List reactive test results: _____
 - *Incomplete for the following reason(s):**
 - Testing was not performed within the required timeframe
 - Health history screening, physical assessment, or medical record review not performed.
 - Testing not performed by a CLIA certified laboratory or not done using a kit FDA approved for screening of live donors.
- Select one of the following options when a donor has incomplete eligibility:**
- No additional donor screening or testing is available.
 - Additional required donor screening and/or testing will follow.

Comments: _____

Eligibility determined by: Print Name: _____ Date: _____

Transplant Center Physician Signature: _____

***A Biohazard Warning Tag MUST be attached to each product bag when the donor is ineligible or if eligibility is incomplete.**

Authorization to Collect an Ineligible or Incomplete Allogeneic Donor

I have explained the communicable disease risks associated with this product to the recipient or the recipient's legally authorized representative. I have obtained consent to use this product from the recipient or the recipient's legally authorized representative. I agree to accept the product. This product is needed to meet an urgent medical need.

Reason for the urgent medical need: _____

Transplant Center Physician Authorization: _____ Date: _____

Versiti Physician Review and Approval: _____ Date: _____

Blank spaces on this form indicate the item is Not Applicable.