Statement of Donor Eligibility

Patient/Recipient:

Insert Hospital Label for Recipient or complete:

Name: _____

D.O.B: _____

Medical Record #: _____

Donor Information (allogeneic donors only):

Insert Hospital Label for Donor or complete:

Name: _____

D.O.B: _____

Medical Record #: _____

Cell Source: ☐ Bone Marrow ☐ Peripheral Blood Stem Cells ☐ Lymphocytes

Date of latest IDM testing performed at CLIA certified laboratory: _____
(If testing was not performed by Michigan Blood contracted laboratory, please attach copy of results.)

Date donor screening forms completed: _____

The donor's eligibility has been determined by Spectrum Health Blood and Marrow Transplant 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

☐ Incomplete for the following reason(s): (apply warning label 4)

- ☐ Testing was not performed by a CLIA certified laboratory or not done using a kit FDA approved for screening of live donors.
- ☐ Testing was not performed within the required timeframe.
- ☐ Health history screening or medical record review not performed.

Select one:

- ☐ No additional donor screening or testing is available.
- ☐ Additional required donor screening and/or testing will follow.

☐ Ineligible for the following reason(s):

- ☐ Infectious Disease Testing
  - ☐ Positive testing, other than CMV (apply warning label 2)
- ☐ Donor Screening (apply warning label 3)
  - ☐ Health history or medical record indicates risk of communicable disease
  - ☐ Physical assessment indicates risk of communicable disease

Comments: _____

_____

Signature _____ Date _____
(Transplant center responsible person)

Print Name _____ Title _____