Statement of Urgent Medical Need
Ineligible Donor

Affix Hospital Label for Recipient or complete:

Recipient Name:_____

DOB:_____

Medical Record #:_____

Donor ID:_____

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 has been deemed ineligible for the following reasons:

☐ Positive Testing Test_____

☐ Physical assessment

_____

_____

☐ Health history 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 name (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

_____ _____

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 these stem cells, I will be monitored for signs and symptoms of infection and treated with antibiotics as appropriate. Depending on my condition, my physician may choose to give me antibiotics or other treatment before I show any signs or symptoms to reduce or remove the possibility of acquiring infection. I agree to accept a product from this donor.

_____ _____ _____

Recipient or legal guardian signature Date Relationship, if legal guardian

_____

Michigan Blood
Medical director signature/date