Autologous Donor Suitability Determination

Please scan or fax the completed form with supporting documentation using state specific contact information below.

State	Address	Email	Phone	Fax
Wisconsin	638 N. 18th St, Milwaukee, WI, 53233	WI-CellCollection@versiti.org	414-937-6154	414-933-6833
Michigan	1036 Fuller Ave NE, Grand Rapids, MI 49503	MI-CellCollection@versiti.org	616-233-8569	616-233-8671
Indiana	3450 N. Meridian St, Indianapolis, IN 46208	IN-CellCollection@versiti.org		

Affix hospital label for donor or complete:

Name: _____

DOB: _____

MRN: _____

Date of Medical Evaluation: _____

After review of donor's medical record, health history and lab results, this donor is deemed to be:

☐ Suitable for cellular therapy collection; Not evaluated for infectious substances per all applicable screening and testing per FDA 21 CFR Part 1271

Versiti Staff: Complete and attach a *Warning Label Tie Tag* to each product bag.

☐ Suitable for cellular therapy collection **with communicable disease risk**

Explanation: Indicates a known communicable disease risk due to reactive test results and/or donor's medical history. Include the reason(s) below and send supporting documentation.

Versiti Staff: Complete and attach a *Biohazard Warning Label Tie Tag* to each product bag.

☒ Not evaluated for infectious substances per all applicable screening and testing per FDA 21 CFR Part 1271

☐ Reactive Test Results for: _____

_____

_____

☐ Communicable Disease Risk due to: _____

_____

_____

Signature of Provider who determined Donor Suitability

Provider Name (print): _____

Provider Signature: _____ Date: _____