Versiti | Blood Center of Michigan
1036 Fuller Ave NE | Grand Rapids MI 49503
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Order to Release Cryopreserved Products

To be Completed by Clinical Program:

Patient Name: _____ Hospital ID: _____ DOB: _____

DIN(s): ☐ All or specify DINs _____

REASON FOR RELEASE FOR DISPOSAL:

- ☐ Patient expired; Date of Death: _____ / _____ / _____
- ☐ Patient no longer transplant candidate
- ☐ Other: _____

Does consent for storage/disposal indicate agreement for use of cells at time of disposal?

☐ No ☐ Yes; Please forward copy of consent to CTL@versiti.org

For products cryopreserved PRIOR TO 2024 or limited information on consent:
Discarded product(s) may be designated for quality control/training purposes ☐ Yes ☐ No

REASON FOR RELEASE FOR TRANSFER:

- ☐ Transfer product(s) for transplant; Facility Name: _____
- ☐ Other: _____

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

_____	_____	_____
Print Name – Transplant Center Physician	Signature – Transplant Center Physician	Date

Forward completed form to CTL@versiti.org

To be Completed by Processing Lab:

The patient's processing records have been reviewed and I approve release of the cryopreserved cells as indicated.

_____	_____	_____
Print Name – Versiti Michigan Medical Director	Signature – Versiti Michigan Medical Director	Date

FINAL DISPOSITION:

- ☐ Product(s) physically discarded
- ☐ Product(s) no longer for clinical use; maintained for quality control/training/research
- ☐ Product(s) transferred (refer to accompanying documents)

Date/Initials _____ Second Check Date/Initials _____

Forward completed form to Clinical Program Transplant Coordinator