

Community Tissue Services
Dayton, OH 45402

AUTOLOGOUS DONOR
"FOR AUTOLOGOUS USE ONLY"

Patient Name: _____ Age: _____

Patient MR/ID# _____ Sex: _____

Hospital: _____

of Specimens in Package: _____ Specimen Type _____

To Be Completed by CTS Only:

Autologous Donor #: _____ Exp: _____

"NOT EVALUATED FOR INFECTIOUS SUBSTANCES"

CTS-600-F-01 Rev 03

Final Storage at -40°C or colder

This is an Example of the Label. The actual label will not print with a header or footer.

Applies To:	CTSC, CTSD, CTSI, CTSMST, CTSNWT, CTSPEN, CTSP, CTSPB, CTSPM, CTST, CTS Website
Review/Approval Requirements:	COO Tissue Services, Executive Director, QRA

REVISION TRACKING			
Rev #	Explanation of Changes <i>(include what changed including reason, when applicable)</i>	Change Initiated By	Implementation Date
Rev 00	Formerly TB Form #284	ES/AW	11-12-10
Rev 01	FILE ONLY - Added CTSPEN to Applies To section. See NCR SM-018-13.	LC	6-28-13
Rev 02	Formerly TR-701-F-01. Updated Autologous series to include all departments involved. Added final storage information. Added CTSPB and CTSPM to Applies To section. Added Executive Director to Review/Approval Requirements.	NJ/AY/HRM/ PJS	8-22-14
Rev 03	Added CTS-Website to Applies To section.	PJS	9-26-14