CALIFORNIA TRANSPLANT SERVICES, INC.
5845 OWENS AVENUE
CARLSBAD, CALIFORNIA 92008
(760) 804-6890 *facsimile* (760) 804-6899

PRESIDENT & CEO: DARYL LIRMAN, CTBS
VICE PRESIDENT: MARC PABLO, CTBS, CEBT

WEBSITE: www.SafetyGraft.org

Autologous Tissue Transfer Request

Patient Name: _____ Patient Trauma name: _____

Patient DOB: _____

Type of autologous tissue: ☐ Bone ☐ Skull Flap ☐ other _____

DATE AND TIME OF PLANNED SURGERY:	
IMPLANTING HOSPITAL NAME:	
IMPLANTING SURGEON NAME:	
IMPLANTING HOSPITAL'S MRN:	
CURRENT STORAGE FACILITY/HOSPITAL:	
SURGEON WHO STORED THE TISSUE:	
CURRENT STORAGE FACILITY MRN:	
REMOVAL SURGERY DATE:	
AUTOLOGOUS TISSUE EXPIRATION DATE: IF NONE STATE "n/a"	

The above patient is under our medical care and we are requesting California Transplant Services, Inc./SafetyGraft to transfer the autologous tissue to our facility for implant. Complete as much of the form as possible, we will contact to other facility for information that is missing. Purchase order hard copy must be issued prior to any movement of tissue. **Please sign below and fax to 760-804-6899.**

REQUESTOR'S NAME:	
REQUESTOR'S TITLE:	
REQUESTOR'S PHONE NUMBER:	
HOSPITAL NAME:	
HOSPITAL DELIVERY ADDRESS:	
HOSPITAL PURCHASE ORDER NUMBER:	
REQUESTER'S SIGNATURE AND DATE:	