*Facility:*___________________________

*Room:*_____________________________

*Start Time:*________________________

Tissue Bank Staff to fill out above

Hartford Hospital Tissue Bank

Request For: Allograft Tissue Products

Date of Request:____

Person ordering/Phone#:____

Patient's Name:____

PT MRN:____

PT DOB: ____

Surgeon:____

Procedure: ____

Date of Surgery:____

Time of Surgery:____

Location: HH OR ☐ **JB4** ☐ **BJI** ☐ **WHSC** ☐ **WC** ☐

Graft Needed	Graft ID#	Expiration Date

When making a request, please complete the information above.

Then Fax completed form to: (860) 545-0010 - Fax
Hartford Hospital Tissue Bank (860) 972-4406 - Phone
Or Email form to: Deborah.Churchill@hhchealth.org , Pamela.doyle@hhchealth.org , or Karl.herbert@hhchealth.org

Tissue Processor Initials:_____________ **Reviewed by Initials:**_______________