

Form: 36018 Revised: 12-02-25

Tissue Order Form

Place Patient Label Here Written Patient Identification Only Accepted During Downtime

Surgeon:			
Date of Procedure:			

115	ssue Order F	orms without a patient label printe	ed from Epic Wi	II not be accep	ted & tissue wi	Il not be dispensed.		
		SE	LECT A LOCA	TION				
			CMC Wound Clinic			□ Surgicare		
	□ S	H OR	SH Wound C					
			IN STOCK					
Room Temperature	Quantity	<u>Product</u>	<u>Size</u>					
		ArthroFlex	□Aflex100: 3.5x3.5cm	□Aflex301: 4.0x7.0cm	□ Aflex402: 2.0x2.5cm	□ Aflex403: 2.5x3.0cm		
		Cancellous Chips	□ 5cc	□ 15cc	□ 30cc			
		DBX Bone Putty	□ 0.5cc	□ 2.5cc	□ 10cc			
		BioCartilage 1cc						
ПО		Kore Fiber	□ 5cc	□ 10cc				
Ro		Flex HD SF2000						
		Epifix	□ 18mm	□ 2x3cm	□ 4x4.5cm			
		Amniofix	□ 16mm	□ 2x12cm				
Frozen		Avance Nerve Graft	□ 1-2x15	□ 1-2x30	□ 2-3x30			
		Achilles Tendon						
		Semitendinosus						
		Anterior Tibial Tendon						
		QuadLink >70mm						
		Bone Tendon Bone (Shaped)						
		Femoral Head						
		Tisseel 4mL						
		*a week's notice need	-	d for special or				
Plea	ase provide a	as much detail as possible and a Note: all special ord				t tissue will be ordered.		
Quan	tity	<u>Tissue Description</u>	<u>Size</u>	V	<u>endor</u>	Vendor Catalog #		
		Incomplete forms will not Fax orders to CMC Blood Bank (6				edia.		
Provider Name (Printed)		Provider Signature			Date/Time			
Read Back & Verified Signature (if provider is not available to sign)								
Contact Person: Phone:								

For Blood Bank Use Only: $\hfill\Box$ Added to tissue calendar Initials: _____ Date:__