BLOOD SAMPLE REQUEST FOR VERIFICATION TYPING

PATIENT DATA	
Patient first name:	Patient last name:
Patient registry:	
Diagnosis:	
Patient ID: (assigned by patient registry)	Patient ID: (assigned by donor registry)
Date of birth: (DD/MM/YYYY)	Gender:
Transplant centre:	

DONOR(s)		
	Donor ID(s)	GRID number(s)
1		
2		
3		
4		
5		
6		

BLOOD SAMPLE REQUIREMENTS (recommended maximum = 50 mL - please provide clinical reasons for greater volumes)			
mls EDTA	Acceptable days of the week to receive samples: (check all that apply)		
mls heparin	☐ Monday	☐ Tuesday	☐ Wednesday
mls ACD	☐ Thursday	☐ Friday	☐ Saturday
mls no anticoagulant	☐ Sunday		
mls			

DISCLAIMER: The cell products collected from the donor are intended solely for the purpose of diagnostic testing on behalf of the above mentioned patient. No other use is permissible. Excess blood volume is allowed for quality control testing only but not for research purposes. Any portion of the cells not used for the intended testing must be disposed of properly. By accepting these cells, the transplant physician also accepts these terms and conditions. Requests for deviations from these terms must be submitted in writing to the donor registry for approval.

Courier Service: VT samples will automatically be shipped using a courier service chosen by the donor centre. The fees for this VT sample are based on the use of this courier service. If you prefer that the samples be shipped using a specific courier service, please list that courier service below. Additional fees may be applied.

Preferred courier service:

PATIENT DATA	
Patient first name:	Patient last name:
Patient registry:	
Patient ID: (assigned by patient registry)	Patient ID: (assigned by donor registry)

Samples to be shipped to:	**Invoice(s)** to be sent to:	Copy shipping address
Institution:	Institution:	
Address:	Address:	
ZIP code:	ZIP code:	
City:	City:	
Country:	Country:	
Attention:	Attention:	
Phone:	Phone:	
Fax:	Fax:	
E-mail:	E-mail:	

COMMENTS:

Person completing form:	Date: (DD/MM/YYYY)	Signature: