Hong Kong Red Cross Blood Transfusion Service Title: Blood Sample Request for Verification Typing Effective Date: 08 December 2022 Document No: WIBMD220F39 Revision No: 01

BLOOD SAMPLE REQUEST FOR VERIFICATION TYPING

PATIENT DATA								
Patient first name:			Patient last name:					
Patient regis	stry:							
Diagnosis:								
Patient ID:			Patient ID:					
(assigned by patient registry)			(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			nday					
ml	S							
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 co	ourier service:							

Approved by: CK Lee Reviewed by: Jennifer Leung, CW Lau Form Author: Bethia Yip Chu Chui Yee, KY Lee

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Patient first name:		Patient last name:						
Patient registry:								
Patient ID: (assigned by patient registry)	Patient II (assigned	Patient ID: (assigned by donor registry)						
Samples to be s	Samples to be shipped to:			Invoice(s) to be sent to: Copy shipping address				
Institution:	Institution:	Institution:						
Address:	Address:	Address:						
ZIP code:	ZIP code:	ZIP code:						
City:	City:	City:						
Country:	Country:	Country:						
Attention:	Attention:							
Phone:	Phone:	Phone:						
Fax:	Fax:	Fax:						
E-mail:	E-mail:	E-mail:						
COMMENTS:								
			<u> </u>					
Person completing form: Date: (DD/N		M/YYYY)	Signature:	Signature:				