

URGENT REQUEST

Office hours delivery: New Zealand Transplantation and Immunogenetics Laboratory (NZTIL) NZ Blood Service 71 Great South Road Epsom 1051 Auckland NEW ZEALAND Telephone: (09) 523 5731 eFax: nztilefax@nzblood.co.nz email: sot@nzblood.co.nz	After Hours/Weekend delivery: Auckland City Hospital Blood Bank Level 2, Building 32 Grafton Road Grafton 1023 Auckland NEW ZEALAND Telephone: (09) 307 2834	NZTIL use only: Received by _____ Registered by _____ Event No.
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FULL AND ACCURATE COMPLETION OF THIS FORM IS ESSENTIAL

This form must accompany the Donor Pack – place inside pack

Step 1. POTENTIAL DONOR DETAILS		
<i>(Attach identification label or complete all written details)</i>		
Family Name		
Given Names		
NHI	Date of Birth	Gender
Ward	Hospital	
Step 2. SAMPLE REQUIREMENTS		
<i>If the potential donor has received a massive transfusion protocol (MTP) please contact NZTIL (09) 523 5731.</i>		
<ul style="list-style-type: none"> ◆ 7 x 9ml CPDA ◆ 2 x 6ml Clotted ◆ 1 x 6ml K2E (EDTA) ◆ 1 x 5ml PPT 		
MIX SAMPLES WELL – DO NOT REFRIGERATE		
Step 3. TESTING REQUIREMENTS		
Blood Bank workup <input checked="" type="checkbox"/> ABO & Rh(D) group Sub type if donor is Group A	NZTIL workup <input checked="" type="checkbox"/> HLA Typing - (HLA-A,-B,-C,-DR,-DQ,-DP) <input checked="" type="checkbox"/> Transplant crossmatch	Infectious Serology workup (To be tested at NZBS) <input checked="" type="checkbox"/> Anti-HIV <input checked="" type="checkbox"/> Anti-HTLV1&2 <input checked="" type="checkbox"/> Anti-CMV <input checked="" type="checkbox"/> Anti-HCV <input checked="" type="checkbox"/> Syphilis <input checked="" type="checkbox"/> HbsAg <input checked="" type="checkbox"/> Anti-HBs <input checked="" type="checkbox"/> Anti-HBcAb <input checked="" type="checkbox"/> Nucleic Acid Testing (NAT)
Step 4. NAME OF REQUESTING PRACTITIONER / COORDINATOR		
Practitioner / Coordinator / Nurse: _____ Signature: _____		
Email Address: _____		
Step 5. SPECIMEN COLLECTOR DECLARATION		
* I certify that the blood specimen(s) accompanying this request form was drawn from the donor named above. * I established the identity of this donor by inspection of their wristband. * Immediately upon the blood being drawn I labelled and signed the specimen(s) at the bedside.		
Date/Time of collection: _____		Contact No: _____
SIGNATURE OF COLLECTOR: _____		Print Name: _____
Doctor/Coordinator/Nurse (please circle)		