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| **Send to:** Auckland Donation Accreditation Laboratory via Local Blood Bank **Weekdays**  **After Hours/Weekends**New Zealand Blood Service Auckland Blood Bank 71 Great South Road Auckland City Hospital Epsom 2 Park Road Auckland 1142 Auckland Tel: (09) 307 5737 (09) 307 2834Email: AucklandDA@nzblood.co.nz  | Received by \_\_\_\_\_\_\_\_\_\_\_\_ Registered by \_\_\_\_\_\_\_\_\_\_\_\_**Event No.**  |
| **FULL AND ACCURATE COMPLETION OF THIS FORM IS ESSENTIAL** |
| **PATIENT DETAILS** – all sections are mandatory(to be completed by sample collector) |
| *(Attach patient identification label or complete* ***all*** *written details)*NHI No. \_\_\_\_\_\_\_\_­­\_\_\_\_\_ DOB \_ \_/ \_ \_/ \_ \_ \_ \_ Gender \_\_\_Family Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Given Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Sample Type:** 🞎 Pre-Mortem 🞎 Post-Mortem  |
| **SAMPLE REQUIREMENTS** |
| **Samples:**  □ 2 x 6mL clotted blood (red or SST yellow top) tubes  □ 1 x 4 - 6mL EDTA (purple top) tube  □ 1 x 6mL PPT (white top) tubes or additional 1 x 6mL EDTA (purple top) tubes**(Mix all tubes well)****Tests Required:** 🞎 Serology (HBV, HCV, HIV, Syphilis) 🞎NAT (HBV, HCV, HIV) 🞎 Anti-HTLV I/II\* (\*post-mortem samplestested by ESR)**Tissue Type:** 🞎 Skin 🞎 Heart Valves 🞎 Eyes 🞎 Amnion 🞎 Unknown Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **SAMPLE LABELLING & ACCEPTANCE CRITERIA** |
| 1. Both tube and request form **MUST** contain the following information:
* Family Name and Given Name(s)
* NHI No. and/or DOB
1. Request form **MUST** be signed by the individual collecting the samples.
2. Date and time of sample collection **MUST** be on request form.
3. Details on tubes **MUST** match those on the accompanying request form. (Patient label or hand-labelling accepted).
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|  **SAMPLE COLLECTION DECLARATION** |
| * I certify that I collected the sample(s) accompanying this request from the patient / donor named above.
* I confirmed the identity of this patient / donor by direct enquiry and/or inspection of their identification band.
* I labelled the samples immediately after collection.

Date/Time of Collection: \_ \_ / \_ \_ / 20\_ \_ at \_ \_ : \_ \_ (24 hrs) Contact No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Labeller: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Doctor / Coordinator / Nurse / Mortuary Staff / Tissue Bank (Please Circle) |
| **FOR REQUESTING TISSUE BANK USE ONLY (FOR SAMPLES COLLECTED BY TISSUE BANK STAFF)** |
| Plasma Dilution – Infusion / Transfusion Worksheet completed and assessed# 🞎 Yes 🞎 No 🞎 N/A #not required for samples referred by Organ Donation New Zealand (ODNZ) Sample suitable for testing: 🞎 Yes 🞎 No 🞎 N/A Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date / time of death: \_ \_ / \_ \_ / 20\_ \_ at \_ \_ : \_ \_ (**post-mortem samples only)**Body refrigeration date / time: \_ \_ / \_ \_ / 20\_ \_ at \_ \_ : \_ \_ (where applicable) **If storing samples, refrigerate at 2-8⁰C within 24 hours and centrifuge within 72 hours of collection.** |

 **TISSUE-ONLY DONATIONS**