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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 2834  Email: [AucklandDA@nzblood.co.nz](mailto: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). | |
| **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**