TISSUE-ONLY DONATIONS

Send to: Auckland Donation Accreditation Laboratory
via Local Blood Bank

Weekdays
New Zealand Blood Service
71 Great South Road
Epsom
Auckland 1142

After Hours/Weekends
Auckland Blood Bank
Auckland City Hospital
2 Park Road
Auckland

Tel: (09) 307 5737 (09) 307 2834
Email: 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 _____

Collected on: _ _ / _ _ / 20_ _ at _ _ : _ _ (24 hrs)

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)

Sample Type: ☐ Pre-Mortem ☐ Post-Mortem

Tests Required (post-mortem only): ☐ NAT (HBV, HCV, HIV) ☐ Anti-HTLV I / II (tested by ESR)

Tissue Type (if known): ☐ Skin ☐ Heart Valves ☐ Eyes 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
2. Request form **MUST** be signed by the individual collecting the samples.
3. Date and time of sample collection **MUST** be on request form.
4. 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

Plasma Dilution – Infusion / Transfusion Worksheet completed and assessed. ☐ Yes ☐ No

Sample suitable for testing: ☐ Yes ☐ No 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 2-8ºC within 24 hours and centrifuge within 72 hours of collection.