NZBLOOD
Te Ratonga Toto O Aotearoa

REQUEST FOR TISSUE TYPING
POTENTIAL ORGAN DONOR TESTING

URGENT REQUEST

Office hour delivery:	**After Hours/Weekend delivery:**	**Laboratory use only:**
New Zealand Transplantation and Immunogenetics Laboratory (NZTIL) NZ Blood Service 71 Great South Rd Epsom 1051 Auckland **NEW ZEALAND** **Telephone: (09) 523 5731** **eFax: nztilefax@nzblood.co.nz** **email: sot@nzblood.co.nz**	Auckland City Hospital Blood Bank Level 2, Building 32 Grafton Road Grafton 1023 Auckland **NEW ZEALAND** **Telephone: (09) 307 2834**	Received by ______________ Registered by _____________ **Event No.**

FULL AND ACCURATE COMPLETION OF THIS FORM IS ESSENTIAL

This form must accompany the Donor Pack – place inside pack

Step 1. **DONOR DETAILS** - sections marked * are mandatory

*(Attach donor identification label or complete **all** written details)*

*NHI No. ___________ *DOB _____________ *Gender ____

*Family Name ____

*Given Names ____

Ethnicity ______________________________

*DHB _________________

*ICU_________________

Step 2. **SAMPLE REQUIREMENTS**

- 7 x 10ml 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 work up	**NZTIL work up**	**Infectious Serology work up** (To be tested at NZBS)
☑ ABO & Rh(D) group Sub type if donor is Group A	☑ HLA Typing - (HLA-A,-B,-C,-DR,-DQ,-DP) ☑ Transplant crossmatch	☑ Anti-HIV ☑ Anti-HTLV1&2 ☑ Anti-CMV ☑ Anti-HCV ☑ Syphilis ☑ HbsAg ☑ Anti-HBs ☑ Anti-HBcore ☑ Nucleic Acid Testing (NAT)

Step 3. **REQUESTING DOCTOR**

SIGNATURE OF REQUESTING DOCTOR ____________________ Print Name _____________________________

Step 4. **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)

Full Address: ____