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

☑ ABO & Rh(D) group

Sub type if donor is Group A

NZTIL work up

☑ HLA Typing - (HLA-A,-B,-C,-DR,-DQ,-DP)

☑ Transplant crossmatch

Infectious Serology work up
(To be tested at NZBS)

☑ 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: ____