



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

Step 1. PATIENT DETAILS – all sections are mandatory

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

NHI No. _____ DOB __/__/____ Gender ____

Family Name _____

Given Name _____

Collected on __/__/20__ at __: __

Step 2. TESTING REQUIREMENTS

Tissue Type: Skin Heart Valves Eyes Other _____

Sample Type: Pre-Mortem Post-Mortem

Samples: 1 x 4mL clotted blood (red or SST yellow top) tubes

2 x 6mL EDTA (purple top) tubes

2 x 6mL PPT (white top) tubes or additional 2 x 6mL EDTA (purple top) tubes

Mix tubes well.

Lab: Refrigerate at 2-8°C, centrifuge within 72 hours of collection.

SAMPLE LABELLING & ACCEPTANCE CRITERIA

- Both tube and request form **MUST** contain the following information:
 - Family Name and Given Name(s)
 - NHI No. or DOB
 - Date and time of sample collection
- Request form and samples **MUST** be signed by the doctor/donor coordinator/nurse/mortuary staff who collected the samples.
- Details on tubes **MUST** match those on the accompanying form. (Patient label or hand-labelling accepted)

Step 3. SPECIMEN LABELLER DECLARATION

- I certify that the blood specimens accompanying this request form were drawn from the patient named above.
- I established the identity of this patient by direct enquiry and/or inspection of their wristband.
- Immediately upon the blood being drawn I labelled and signed the specimens in presence of the patient.

Date/Time of Collection _____ Contact No. _____

Signature of Labeller _____ Print Name _____

Doctor/Coordinator/Nurse/Mortuary Staff (Please Circle)