

NEW SOUTH WALES TRANSPLANTATION AND IMMUNOGENETICS



Sample Delivery (24 hours)
Dock A, Level 3 17 O'Riordan Street
Alexandria NSW 2015

ASHI accreditation: 02-9-AU-01-1
NATA accreditation: 18808

Enquiries
8:00am to 4:30pm
+61 2 9234 2322 (phone)
+61 2 9234 2326 (fax)
ttsosegnsw@redcrossblood.org.au
www.transfusion.com.au
Sample bookings
ttbookings@redcrossblood.org.au

Solid Organ Transplant Request Form

Urgent results: Please contact the laboratory directly on the above **phone** number or **email** address.

LABORATORY USE ONLY		
SPECIMEN ID		DATE AND TIME STAMP
TRANSPLANT RECIPIENT OR DONOR DETAILS <small>Please fill or affix hospital label here – three forms of ID required</small>		
SURNAME (Please print)		DOB <input type="radio"/> FEMALE <input type="radio"/> MALE
GIVEN NAMES		MRN / MEDICARE No. (Circle and complete)
ADDRESS		<input type="radio"/> DONOR <input type="radio"/> RECIPIENT <small>If donor, complete recipient details below</small>
NAME OF TRANSPLANT RECIPIENT AND DOB (If samples are from the donor then complete individual request forms for each family member)		DIAGNOSIS
RELATIONSHIP OF DONOR TO RECIPIENT		
REFERRED BY	CONTACT NUMBER	TRANSPLANT HOSPITAL
REPORT TO		COPY OF REPORT TO
NAME		NAME
ADDRESS		ADDRESS
EMAIL		EMAIL
TESTING REQUIREMENTS <small>Refer to website for sample volume requirements for paediatric patients or patients with low cell counts</small>		
ORGAN: <input type="checkbox"/> KIDNEY <input type="checkbox"/> PANCREAS <input type="checkbox"/> PANCREAS ISLETS <input type="checkbox"/> HEART <input type="checkbox"/> LUNG <input type="checkbox"/> LIVER <input type="checkbox"/> OTHER (Please specify)		
<input type="checkbox"/> Registration for Transplant Waiting List (TWL) <input type="checkbox"/> Live Organ Transplant Workup (LOD) <input type="checkbox"/> Australian Kidney Exchange (AKX) Program		
REGISTRATION FOR TRANSPLANT WAITING LIST (TWL)		
<input type="checkbox"/> INITIAL TESTING (20mls ACD + 10ml Clot)		<input type="checkbox"/> RE-ENTRY (20mls ACD + 10ml Clot)
<input type="checkbox"/> CONFIRMATORY TESTING (20mls ACD + 10ml Clot)		<input type="checkbox"/> MONTHLY CLOTTED SAMPLE (10ml Clot)
LIVE ORGAN TRANSPLANT WORKUP (LOD) <small>Samples must be booked in via above email</small>		
<input type="checkbox"/> INITIAL TESTING (Recipient: 40mls ACD + 10ml Clot. Donor: 40mls ACD)		PROPOSED TRANSPLANT DATE
<input type="checkbox"/> CONFIRMATORY TESTING (Recipient: 40mls ACD + 10ml CLOT. Donor: 40mls ACD)		
<input type="checkbox"/> FLOW CYTOMETRIC CROSSMATCH (Recipient: 60mls ACD + 10ml Clot. Donor: 60mls ACD)		Note: Non-standard testing must be pre-arranged with the laboratory.
HLA DONOR SPECIFIC ANTIBODY SPECIFICITY		CAUSE
<input type="checkbox"/> PRE-TRANSPLANT (10ml CLOT/SERUM) <input type="checkbox"/> POST-TRANSPLANT (10ml CLOT/SERUM)		<input type="checkbox"/> ROUTINE <input type="checkbox"/> BIOPSY or REJECTION
ADDITIONAL TESTING		
<input type="checkbox"/> OTHER (Please specify)		
SAMPLE COLLECTION		
Recommended transportation: Whole blood samples: Room temperature. Separated serum samples: <4°C. Samples should be received by laboratory within 24 hours of collection. Ensure samples are packed in a secure container and the outside of the transport container is clearly labelled with the delivery address		
COLLECTOR NAME	DATE AND TIME OF COLLECTION	ACCESSION No.
PATIENT SIGNATURE (Confirming samples are labelled correctly)		DATE
SAMPLE TYPE: <input type="checkbox"/> Whole blood (ACD) <input type="checkbox"/> CLOT <input type="checkbox"/> OTHER (Please specify)		
PRACTITIONER (OR DELEGATE) SIGNATURE		DATE OF REQUEST

COMPLETED
BY COLLECTOR