



**Mendez National Institute of Transplantation**  
 MNIT Serology Laboratory- CLIA # 05D0962012  
 221 South Figueroa Street, Suite 510  
 Los Angeles, CA 90012  
 Tel 213.229.3654 Fax 213.229.3659

Accession Number: *(Lab Use Only)*

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Time Received: \_\_\_\_\_

Time Confirmed: \_\_\_\_\_

**MNIT LABORATORY TESTING REQUISITION**

**Donor/Sample Information:**

(Donors Last Name/ ID#)	(Donors First Name)	(Middle Initial)	Date of Birth	Gender F / M	Age
Date Collected	Time Collected	Collect Comment	Specimen ID#	Additional ID#	Additional ID#
<input type="checkbox"/> Tissue Donor	<input type="checkbox"/> Pre-Mortem	<input type="checkbox"/> Post-Mortem	<input type="checkbox"/> Pre-Transfusion	<input type="checkbox"/> Post-Transfusion	<input type="checkbox"/> Research <input type="checkbox"/> Maternal <small>(Maternal: ≤ 30 Days of Age)</small>

By ordering a profile, you are acknowledging that you are ordering & will receive results for specified components.

**Report Results To:**

<input type="checkbox"/> Idaho Lions Eye Bank 1090 N. Cole Boise, ID 83704 Fax: (208) 338-6543	<input type="checkbox"/> Send Additional Reports To:  <input type="checkbox"/>
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**Laboratory Panels:**

<input type="checkbox"/> <b>Tissue Donor Panel 1</b> HIV 1&2, HBs Ag, HBc Total, HCV, HIV / HCV / HBV NAT, RPR, ABO/ Rh, & HTLV I/II <span style="float:right"><i>(Complete)</i></span>	<input type="checkbox"/> <b>Tissue Donor Panel 2</b> HIV 1&2, HBs Ag, HBc Total, HCV, HIV / HCV / HBV NAT, RPR, & HTLV I/II <span style="float:right"><i>(No ABO / Rh)</i></span>	<input type="checkbox"/> <b>Tissue Donor Panel 3</b> HIV 1&2, HBs Ag, HBc Total, HCV, HIV / HCV / HBV NAT, & RPR <span style="float:right"><i>(No HTLV &amp; ABO / Rh)</i></span>
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**Individual Tests:**

Chagas (T. Cruzi Ab)  
  West Nile Virus IgM  
  West Nile Virus NAT  
  Hgb A1c  
  ABO/Rh  
  HIV / HCV / HBV NAT  
  HTLV I/II  
5-55 yrs

Other(s): \_\_\_\_\_

**Please Complete for ALL NAT Testing:**

Centrifuged:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If Yes Please Provide Date: _____ and Time: _____
Refrigerated:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If Yes Please Provide Start Date: _____ and Time: _____

**Coordinator Full Name** *(Please Print First and Last Name):*

Phone # _____	Fax # _____

ILEB Team Use Only			
Tube Type: <small>(Red top, EDTA)</small>	Manufacturer:	Lot Number:	Expiration Date:

For NIT Use Only	
SPECIMENS RECEIVED	
Specimen Tubes	Specimen Quality
_____ Red	_____
_____ EDTA	_____
_____ Tiger	_____
_____ Plasma	_____
_____ Serum	_____
<input type="checkbox"/> Accept <input type="checkbox"/> Reject	

Comments / Update By: \_\_\_\_\_

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