



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)*

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"/> SightLife 211 Yale Avenue N. Suite 450 Seattle WA 98109-5490 Fax: (206) 838-4661	<input type="checkbox"/> Northwest Tissue Services 501 SW 39 th Street Renton, WA 98057 Fax: (206) 343-5043	<input type="checkbox"/> Send Additional Reports To:
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Laboratory Panels:

<input type="checkbox"/> Tissue Donor Panel 1 HIV 1&2, HBs Ag, HBc Total, HCV, HIV / HCV / HBV NAT, RPR, ABO/ Rh, & HTLV I/II (Complete)	<input type="checkbox"/> Tissue Donor Panel 2 HIV 1&2, HBs Ag, HBc Total, HCV, HIV / HCV / HBV NAT, RPR, & HTLV I/II (No ABO / Rh)	<input type="checkbox"/> Tissue Donor Panel 4 HIV 1&2, HBs Ag, HBc Total, HCV, HIV / HCV / HBV NAT, RPR, & ABO / Rh. (No HTLV)	<input type="checkbox"/> Research Only Panel 1 HIV 1&2, HBs Ag, & HCV
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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 # _____

SL / NWTS 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: _____
