



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

Sample Information:

(Last Name/ ID#)	(First Name)	(Middle Initial)	Date of Birth	Gender	Age
				F / M	
Date Collected	Time Collected	Collect Comment	UNOS ID#	Additional ID#	Additional ID#
<input type="checkbox"/> LRD (Living Related Donor) <input type="checkbox"/> Pre-Mortem <input type="checkbox"/> Post- Mortem <input type="checkbox"/> Pre-Transfusion <input type="checkbox"/> Post-Transfusion <input type="checkbox"/> Organ Donor <input type="checkbox"/> Research (Maternal: ≤ 30 Days of Age) <input type="checkbox"/> Maternal					
By ordering a profile, you are acknowledging that you are ordering & will receive results for specified components. All organ remaining/ residual samples are archived.					

Report Results To:

Transplant Center: _____
 Send Additional Reports To: _____
 Address _____
 Phone#: _____
 Fax #: _____

Laboratory Panels:

<input type="checkbox"/> NAT Testing (Results within 24 Hours) HIV / HCV / HBV NAT- Nucleic Acid Testing for HIV-1,HCV, & HBV <i>Requires 2 lavender tops</i>	<input type="checkbox"/> NAT Testing <u>STAT</u> (Results within 6-8 Hours) HIV / HCV / HBV NAT- Nucleic Acid Testing for HIV-1,HCV, & HBV <i>Requires 2 lavender tops</i>
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Individual Tests:

<input type="checkbox"/> Chagas (T. Cruzi Ab) <input type="checkbox"/> West Nile Virus IgM <input type="checkbox"/> West Nile Virus NAT <input type="checkbox"/> ABO/Rh	<input type="checkbox"/> HIV 1 & 2 <input type="checkbox"/> HTLV I/II <input type="checkbox"/> RPR	<input type="checkbox"/> HCV Ab <input type="checkbox"/> CMV IgG <input type="checkbox"/> CMV IgM	<input type="checkbox"/> HBc Total Ab <input type="checkbox"/> HBc IgM <input type="checkbox"/> HBs Ag	<input type="checkbox"/> EBV IgG <input type="checkbox"/> EBV IgM <input type="checkbox"/> EBNA <input type="checkbox"/> HgbA1c 5-55 yrs
<input type="checkbox"/> Other(s): _____				

Please Complete for ALL NAT Testing:

Centrifuged: Yes No If Yes Please Provide Date: _____ and Time: _____
 Refrigerated: Yes No If Yes Please Provide Start Date: _____ and Time: _____

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

Phone #	Fax #

Transplant Center Team Use Only			
Tube Type: (Red top, EDTA)	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: _____