



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 Tissue Laboratory Services
 REQUISITION**

Donor Name or ID# (Last) (First) (Initial)	<input checked="" type="checkbox"/> Utah Lions Eye Bank 65 Mario Capecchi Drive Salt Lake City, UT. 84132 801.581.4644 - Fax Send Additional Reports To: <input type="checkbox"/> <input type="checkbox"/>
Date of Birth Gender Age	
Date Collected Time Collected Collect Comment	
Additional ID # Additional ID # Specimen ID #	
Sample Information <input type="checkbox"/> Pre-Mortem <input type="checkbox"/> Living Donor <input type="checkbox"/> Cord Blood <input type="checkbox"/> Post-Mortem (non-Cadaveric) <input type="checkbox"/> Maternal <input type="checkbox"/> Pre-Transfusion <input type="checkbox"/> Organ <input type="checkbox"/> Flow <input type="checkbox"/> Post-Transfusion <input type="checkbox"/> Research	
By Ordering a Profile, You are Acknowledging that you are Ordering and will Receive Results for Specified Components All Remaining / Residual Samples are Archived	

<input type="checkbox"/> Tissue Donor Profile Panel 1 HIV 1&2, HBsAG, HBc Total, HCV, HIV/HCV NAT, RPR, HTLV 1/2, ABO/Rh	<input type="checkbox"/> Tissue Donor Profile Panel 2 HIV 1&2, HBsAG, HBc Total, HCV, HIV/HCV NAT, RPR, HTLV 1/2, (No ABO/Rh)	<input type="checkbox"/> Tissue Donor Profile Panel 3 HIV 1&2, HBsAG, HBc Total, HCV, HIV/HCV NAT, RPR, (No HTLV or ABO/Rh)
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Individual Tests

<input type="checkbox"/> ABO/Rh	<input type="checkbox"/> HBs Ag	<input type="checkbox"/> CMV Total	<input type="checkbox"/> HTLV I/II
<input type="checkbox"/> HBc Total Ab	<input type="checkbox"/> HCV Ab	<input type="checkbox"/> EBV IgG	<input type="checkbox"/> RPR
<input type="checkbox"/> HBc IgM	<input type="checkbox"/> CMV IgG	<input type="checkbox"/> EBV IgM	<input type="checkbox"/> HIV-1/HCV NAT
<input type="checkbox"/> HBs Ab	<input type="checkbox"/> CMV IgM	<input type="checkbox"/> HIV 1&2 Ab	<input type="checkbox"/> WNV NAT

Please complete for ALL NAT Testing

Centrifuged: Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, If Yes, Date: _____ and Time: _____
Refrigerated: Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, (Start) Date: _____ and Time: _____ (End) Date _____ And Time: _____
Frozen: Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, (Start) Date: _____ and Time: _____ (End) Date: _____ and Time: _____

Coordinator Name: _____	Telephone Number: _____
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