



7450 Mason Montgomery Rd Ste 109 Mason, Ohio 45040

Phone: (513) 648-7900 Fax: (513) 906-5819

Email: SpecialChemistry@thechristhospital.com**Special Chemistry Laboratory Requisition****DONOR IDENTIFICATION INFORMATION**

Donor ID		Date of Birth:
Referral #		Date/Time of Death (post-mortem only)
Gender	☐ Male ☐ Female ☐ Other _____	Additional ID:

BILLING INFORMATION

Account	☐ The Cincinnati Eye Bank (4000 Executive Park Drive Suite 420 Cincinnati, OH 45241 Ph: 513-861-3716)
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SPECIMEN INFORMATION

TUBE TYPE	COLLECTION INFORMATION	TRANSFUSION STATUS	SAMPLE INFORMATION	ADDITIONAL INFORMATION
EDTA QTY: ____	DATE: _____ TIME: _____ ☐ CST ☐ PST ☐ EST ☐ MST	☐ Pre ☐ Post	☐ Living ☐ Pre-Mortem ☐ Post-Mortem	Centrifuge: D/T _____ Refrig: D/T _____ Frozen: D/T _____
SST QTY: ____	DATE: _____ TIME: _____ ☐ CST ☐ PST ☐ EST ☐ MST	☐ Pre ☐ Post	☐ Living ☐ Pre-Mortem ☐ Post-Mortem	Centrifuge: D/T _____ Refrig: D/T _____ Frozen: D/T _____
RED QTY: ____	DATE: _____ TIME: _____ ☐ CST ☐ PST ☐ EST ☐ MST	☐ Pre ☐ Post	☐ Living ☐ Pre-Mortem ☐ Post-Mortem	Centrifuge: D/T _____ Refrig: D/T _____ Frozen: D/T _____
OTHER QTY: ____	DATE: _____ TIME: _____ ☐ CST ☐ PST ☐ EST ☐ MST	☐ Pre ☐ Post	☐ Living ☐ Pre-Mortem ☐ Post-Mortem	Centrifuge: D/T _____ Refrig: D/T _____ Frozen: D/T _____

TEST PROFILES

- ☐ **Eye, Routine** (HBc Ab Total, HBs Ag, HCV Ab, HIV Ag/Ab, HIV/HCV/HBV NAT, RPR)
- ☐ **Tissue, Routine** (HBc Ab Total, HBs Ag, HCV Ab, HIV Ag/Ab, HIV/HCV/HBV NAT, HTLV I/II, RPR)
- ☐ **Archive Only**

INDIVIDUAL TESTS

CMV IgG (R, S) *	HCV Ab (E, R, S)
CMV IgM (R, S) *	HIV Ag/Ab (E, R, S)
CMV Ab Total (E, R)	HIV/HCV/HBV NAT (E, R, S)
EBV IgG (R, S) *	HTLV I/II (E, R, S)
EBV IgM (R, S) *	RPR (E, R)
HBc Ab IgM (E, R, S) *	Syphilis Ab (E, R)
HBc Ab Total (E, R, S)	Toxo IgG (R, S) *
HBs Ag (E, R, S)	Toxo IgM (R, S) *

KEY: E = EDTA; R = Plain Red Top; S = SST*** TESTS CANNOT BE RUN ON POST-MORTEM SPECIMENS****DONOR HISTORY**

Please check all known positives:

- ☐ HBV
- ☐ HCV
- ☐ HIV
- ☐ Other, please specify _____

PROVIDE REPORTS TO:

- ☐ Network for Hope
- ☐ Other, please specify _____

FOR LAB USE ONLY

Labels:
Qualified specimen: ☐ Yes ☐ No Tech: _____ Date: _____