THAWING REQUEST FORM

Operator / Phone number:	0789 44 89 66			
Delivery address	Contact: Lily Boeschlin Street: Hardeggerstrasse 22, 3008 Bern City: Nation: Other: **Delivery adresse:** Dr. Colette C. Camenisch Beethovenstrasse 9 8002 Zürich Tel: 044 545 1444			
Requested delivery	**Time:**	14:30	**Date:**	21.05.2025
Patient name	Kiki REDJEKI			
SSCB ID (on certificate)	AT-_ _00102 _			
Date of collection (on certificate)	19-12-2022			
Gender / Date of Birth	Female / 11.01.1974			
Number of Cryo-vials to recall	1 Vials			

Type of shipment	☐ **FROZEN** For export in dry-shipper (Dry-shipper and shipment costs not included) **Date and Time of pick-up:**	☒ **THAWED** For immediate reinfusion **Required Syringes for Reinfusion:** ☐ 5 / ☒ 6 (please specify) **Required Volume per Syringe:** ☒ 0.5 / ☐ _____ (please specify)

Observations: ☐**No** ☐**YES**, please specify

06.05.2025
Date / Signature