THAWING REQUEST FORM

Operator / Phone number:	_____ / _____			
Delivery address	Contact: Street: City: Nation: Other:			
Requested delivery	**Time:**		**Date:**	
Patient name				
SSCB ID (on certificate)	AT-_ _ _			
Date of collection (on certificate)				
Gender / Date of Birth	_____ / _____			
Number of Cryo-vials to recall	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 / ☐ _____ (please specify) **Required Volume per Syringe:** ☐ 0.5 / ☐ _____ (please specify)

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

_____
Date / Signature