

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)		☐ THAWED For immediate reinfusion
	Date and Time of pick-up:		Required Syringes for Reinfusion: ☐ 5 / ☐ _____ (please specify)
			Required Volume per Syringe: ☐ 0.5 / ☐ _____ (please specify)
Observations: ☐ No ☐ YES, please specify			
 _____ Date / Signature			