THAWING REQUEST FORM

Operator / Phone number:	_0789 44 89 66_____ / _____			
Delivery address	Contact Lily Boeschlin Street: Hardeggerstrasse 22 City: 3008 Bern Nation: Delivery adresse: Dr. Colette C. Camenisch Other: Beethovenstrasse 9 8002 Zürich Tel: 044 545 1444			
Requested delivery	**Time:**	16:00 - 17:30 06:45 - 07:00	**Date:**	13.08.2025 or 14.08.2025
Patient name	Juliati Sapta Dwi Magdalena	14.08.2025 at 6:45 - 7:00		
SSCB ID (on certificate)	AT-_ _ _			
Date of collection (on certificate)				
Gender / Date of Birth	Female, 26 July 1972 / ___			

Number of Cryo-vials to recall	2 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 / ☐ _16 X _1ml_(please specify

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

08.08.2025
Date / Signature