Sample Collection Form

HOSPITAL ……………………………….

HOSPITAL NO …………………………..

CODE ALLOCATION …………………………….

NAME ……………………………….

DOB …………………………………

ETHNIC ORIGIN ……………………..

Date/Time of Collection:

Samples Collected (please tick)

Green heparin bottle ☐

Serum bottle ☐

EDTA bottle ☐

Biopsy ☐

Biopsy Date:

Please send to:

FAO: Lucy Marshall,
Rheumatology Unit, Institute of Child Health,
30 Guilford Street, London, WC1N 1EH

FOR LAB USE (at Institute of Child Health)

DATE………………………… Processed by: ...…………………….

Time into lab:

Time started processing:

Time into freezer:

	Sample one		Sample Two		Box Number
	Volume/ Number	Number of Aliquot	Volume/ Number	Number of Aliquot	
Plasma					
Serum					
Cells					

GENOMICS:

PLASMA LYSIS : 1ml ☐ **5ml** ☐

FICOL PELLET YES ☐ **No** ☐