

CRYOGENE LAB	GOVERNING SOP: SAMPLE HANDLING
DOCUMENT TYPE	FORM
SOP NUMBER / FORM	201 FD
EFFECTIVE DATE/ FORM REVISION #	06-13-2011/004

FORM D: SAMPLE RETRIEVAL/DELIVERY REQUEST

To Schedule Retrieval/Delivery/Shipment of Samples-Please fax completed form to
713-664-2796 Note: If unable to fax form, please Phone: 713-664-1600

COMPLETE THE FOLLOWING:

Request Date	Institution	Contact Name/ID	
Desired Delivery Date*	Desired Delivery Time(s)	Contact Phone #	
DELIVERY LOCATION Department/Building/ Room #		Investigator Name	
FOR SHIPMENT ONLY OR <input type="checkbox"/> N/A	COURIER <input type="checkbox"/> Fed Ex* <input type="checkbox"/> World Courier <input type="checkbox"/> Other: _____	Ship To Address	
Preferred Courier Account #			
SAMPLE INFORMATION (Attach separate sheet if required/preferred)			
Sample Label Information (attach separate list if needed)		CryoGene Tracking Number	
Transport Conditions (check one) <input type="checkbox"/> Dry Ice <input type="checkbox"/> LN2 vapor <input type="checkbox"/> Other (specify): _____	Storage Requirements (check one) <input type="checkbox"/> -80C <input type="checkbox"/> -20C <input type="checkbox"/> LN2 vapor <input type="checkbox"/> LN2 liquid <input type="checkbox"/> 2-8C <input type="checkbox"/> Room Temp <input type="checkbox"/> Other (specify): _____	Duration: <input type="checkbox"/> Temporary <input type="checkbox"/> Indefinite <input type="checkbox"/> Unknown	
Sample Container Type(s) & # of each	<input type="checkbox"/> Vials #: _____ <input type="checkbox"/> Bags #: _____ <input type="checkbox"/> Cassettes #: _____ <input type="checkbox"/> Boxes #: _____ <input type="checkbox"/> Full Freezer #: _____ <input type="checkbox"/> Other (specify): _____		
Check all that apply:	TYPE: <input type="checkbox"/> Virus <input type="checkbox"/> Bacteria <input type="checkbox"/> Cell Line (specify): _____ <input type="checkbox"/> Blood <input type="checkbox"/> Tissue <input type="checkbox"/> Other (specify): _____	PURPOSE: <input type="checkbox"/> CLINICAL <input type="checkbox"/> RESEARCH <input type="checkbox"/> Other (specify): _____	STORAGE & HANDLING: <input type="checkbox"/> Infectious <input type="checkbox"/> Not Infectious
COMMENTS:			
Authorized By:		Date:	

CryoGene USE ONLY (For Dry Ice Deliveries) or N/A

Are requested shipment dates acceptable (*e.g. Fed Ex-Mon-Wed shipment and avoid Holidays)?

Yes No Reviewed By Initials/Date _____ Confirmed By Initials/Date: _____

If No, contact CryoGene client and document changes on this form.

Controlled Copy-For Client Use