Barcelona Tissue Bank
BANC DE SANG I TEIXITS

REQUEST FOR
CRYOPRESERVATION / THAWING OF OVARIAN TISSUE

Sent by email to **bt@bst.cat**

1. DETAILS OF THE REQUESTING HOSPITAL OR CENTRE

Implanting centre

Requesting Dr. (full name) | Department

Address

Postcode | Town/City

Phone no. | Email

Address of delivery

Postcode | Town/City

Billing centre

Phone no. | Email

CIF (Tax ID code) | Contact person

Policyholder/Policy no.

Authorization | Order no./Purchase order

2. DONOR DETAILS

Full name | **Medical history no.**

Age | Blood group | Written authorization from recipient ☐ Yes ☐ No

CIP/ID card | Diagnosis

3. INTERVENTION

Date | Time | Place/Operating theatre

4. PROCEDURE REQUESTED

☐ **BT6005** Ovarian tissue cryopreservation

☐ **BT6006** Ovarian tissue thawing

1. I hereby state that I know and meet all the stipulations of Royal Decree Law 9/2014 on the use of human tissues for transplantation.
2. I agree to provide information to the bank issuing the tissue on incidents related to the transplantation and its course.

Transplanting physician's medical licence no.

Signature

Date

The cost of transportation shall always be borne by the applicant.

R-SB-097 / Versió 1 (EN)

Salut/ BANC DE SANG I TEIXITS

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