New York Eye and Ear Infirmary of Mount Sinai
Department of Pathology and Laboratory Medicine
310 East 14th Street New York, NY 10003
212-979-4156

REQUEST FOR RELEASE OF AUTOLOGOUS SERUM EYE DROPS

SECTION ONE-REQUEST: TO BE COMPLETED BY REQUESTING OPTHALMOLOGIST

Patient name: _____ Date of Birth: _____

NYEE-Affiliated Physician name: _____

Office Address: _____

Office Phone: _____ Office Fax: _____

Signature: _____ Date: _____

Shipping Information:
Collection, processing, testing and shipping of blood requires 3 weeks after donation for ASED units. The New York Blood Center will contact the patient who will then schedule to pick up the drops.
Please send completed SIGNED form before EACH product request (Refills Not Accepted) to 212-677-1284

SECTION TWO-RECEIPT: TO BE COMPLETED BY NYEE TECHNOLOGIST

Receipt Date: _____ Receipt Time: _____ Received by: _____

Patient name: _____ Date of Birth: _____

Donor Identification Number or Sticker _____

Visual Inspection: Check for presence of dry ice, product integrity and appearance and label content

Dry Ice ☐Yes ☐ No **Product** ☐Yes ☐ No **Label** ☐Yes ☐ No

SECTION THREE: TO BE COMPLETED BY NYEE LABORATORY STAFF AT ISSUE

Issue Date: _____ Issue Time: _____ Issued by: _____

Patient name: _____ Date of Birth: _____ ID Check ☐Yes ☐ No

Donor Identification Number or Sticker _____

Visual Inspection: Check for presence of dry ice, product integrity and appearance and label content

Dry Ice ☐Yes ☐ No **Product** ☐Yes ☐ No **Label** ☐Yes ☐ No

Patient Signature*: _____ Date: _____
**I have received my Autologous Serum Eye Drops*
Issued by: _____ Signature _____ Date: _____

Verified by: _____ Signature _____ Date: _____