Indiana University Health

BIOREPOSITORY REQUEST FORM

PRINCIPAL INVESTIGATOR INFORMATION

Name: _____

Email: _____

Department/Institution: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

LABORATORY SHIPPING ADDRESS (if different from Principal Investigator)

Name: _____

Email: _____

Department/Institution: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

BILLING ADDRESS

◯ Same as Shipping ◯ Same as PI ◯ Other (below)

Name: _____

Email: _____

Department/Institution: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

STUDY INFORMATION

IRB #: _____

IRB approval date: _____

What are you requesting? _____

☐ **Blood:**

- ☐ Fresh
- ☐ Frozen

Blood Collection Tube type:

- ☐ No additive
- ☐ EDTA
- ☐ Sodium Heparin
- ☐ Lithium Heparin
- ☐ Sodium Citrate
- ☐ Other: Please list _____

Optimal volume: _____

Minimal volume: _____

Blood type:

- ☐ Plasma
- ☐ Serum
- ☐ Unprocessed specimen

Quantity: (number of cases) _____

☐ **Urine:**

- ☐ Fresh
- ☐ Frozen

Optimal volume: _____

Minimal volume: _____

Quantity: (number of cases) _____

☐ **Tissue:**

- ☐ Fresh
- ☐ Frozen
- ☐ Fixed

Solid tissue anatomic site: _____

Optimal weight: _____

Minimal weight: _____

Tissue type: _____

Quantity: (number of specimens) _____

☐ **Special collection of fluid or tissue:**

- ☐ Fresh
- ☐ Frozen

Type:

- ☐ CSF
- ☐ Synovial Fluid
- ☐ Saliva
- ☐ Bone
- ☐ Cartilage

Quantity: (number of cases) _____

Optimal volume/weight: _____

Minimal volume/weight: _____

Submit Form