

**Yale Clinical Trial Tissue Services (YCTTS)
Tissue Request Form**

Date _____

Institution _____

Contact Person _____

Email _____ Telephone _____

PI/CI Name _____

**RETURN COMPLETED FORM
via email to:**

Yale Clinical Trial Tissue Services
Email: ctts@yale.edu
FAX: 203.737.8388

Project Charging: Credit Card _____ Validation/PIN no. _____ Expiration Date _____

Invoice Number _____

Billing Address:

Name _____

Address _____

Address #2 _____

City _____

State _____ Zip Code _____

Shipping Address: Same as Billing Address

Name _____

Address _____

Address #2 _____

City _____

State _____ Zip Code _____

NOTE: FOR BEST SERVICE COMPLETE ENTIRE FORM

Please fill out below and check all that apply

Department _____

Project Name _____

Sponsor _____

IRB Number _____

Please send via email:

Signed Patient Consent
Pathology Report
Signed IRB Protocol
or IRB Exception

Patient Name	Date of Birth	MRN	Accession No.
Date of Consent	Consent Expiration		

	Tissue Type				
	Primary	Mets	Pos LN	Neg LN	Marginal
# of unstained slides					
# of H&E					
Block	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

For CTTS use only:

Pathologist:

Review Date:

Slide Selection Date: