



Please send the completed form(s) to nuth.vivobiobank@nhs.net, or alternatively by post to: VIVO Biobank Manager, Wolfson Childhood Cancer Research Centre, Hershel Building Level 6, Newcastle University, Newcastle upon Tyne, NE1 7RU, UK

Sample Registration Form

Centre Number

Patient Number

Hospital Name

4 - Sample registration

Sample type	Other:	Liquid tube type:	4.01		
Sample Code	Sample ID.		4.02		
Time point	Time point No.	Other time point	4.03		
Treatment received (please specify)			4.04		
Date sample taken	<input type="text"/> / <input type="text"/>	<input type="text"/>	4.05		
Primary/Secondary Malignancy	Primary	Secondary	4.06		
Chemotherapy	Pre	Mid	Post	None	4.07
Radiotherapy	Pre	Mid	Post	None	4.08
Immunotherapy	Pre	Mid	Post	None	4.09
Date of relapse (if appropriate)	<input type="text"/> / <input type="text"/>	<input type="text"/>	4.10		
Other details (e.g. secondary tumour)	<input type="text"/>			4.11	
Tumour Location in the body	<input type="text"/>			4.12	
Pathology Laboratory Specimen Number	<input type="text"/>			4.13	
Tissue Type	Tumour <input type="checkbox"/>	Normal <input type="checkbox"/>	4.14		
Tumour Source	Primary <input type="checkbox"/>	Metastatic <input type="checkbox"/>	Benign <input type="checkbox"/>	4.15	
Was surgery performed as part of treatment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	4.16	
Was this sample taken during that surgery?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	4.17	

5 - Sample storage details

Sample storage location (i.e. freezer, shelf etc)	Freezer <input type="checkbox"/>	Shelf <input type="checkbox"/>	Box <input type="checkbox"/>	4.01	
Storage condition	-80 °C <input type="checkbox"/>	-150 °C <input type="checkbox"/>	LN ₂ <input type="checkbox"/>	RT <input type="checkbox"/>	4.02
Number of individual	Blocks <input type="text"/>	Aliquots <input type="text"/>	Sections <input type="text"/>	4.03	
Sample size	Value <input type="text"/>	Units <input type="text"/>	(i.e. ml, µl, mm ³)		4.04
Tumour cell content (%)	<input type="text"/>				4.05
Cold ischemia time	Hours <input type="text"/>	Minutes <input type="text"/>	4.06		
Date received in laboratory	<input type="text"/> / <input type="text"/>	<input type="text"/>	4.07		
Date locally stored	<input type="text"/> / <input type="text"/>	<input type="text"/>	4.08		
Signed by	<input type="text"/>				4.09
Job Title	<input type="text"/>				4.10
Date	<input type="text"/> / <input type="text"/>	<input type="text"/>	4.11		

6 - Comments

Other comments	<input type="text"/>	6.01
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7 - Signed

Signed by	<input type="text"/>	7.01	
Job Title	<input type="text"/>	7.02	
Date	<input type="text"/> / <input type="text"/>	<input type="text"/>	7.03

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THIS FORM MUST ONLY BE USED AFTER A PATIENT REGISTRATION FORM HAS BEEN COMPLETED

Filename should match sample ID