Blood Tube Chain of Custody Form

INSERT PATIENT INFORMATION HERE

Centers for Disease Control and Prevention
NCEH/DLS
4770 Buford Hwy, NE MS F-20
Atlanta, GA 30341-3724 USA

Number of tubes collected: Purple_____, Green/Gray_____

Date Time

Collected By: _____
(Printed Name) (Signature)

Reason: _____

Received By: _____
(Printed Name) (Signature)

Reason: _____

Received By: _____
(Printed Name) (Signature)

Reason: _____

Received By: _____
(Printed Name) (Signature)

Reason: _____

Received By: _____
(Printed Name) (Signature)

Reason: _____

Received By: _____
(Printed Name) (Signature)

Reason: _____

Received By: _____
(Printed Name) (Signature)

Reason: _____