S20

REQUEST FOR EXTENDED DONOR HLA TYPING

☐ Urgent request

PATIENT DATA	
Patient name:	
Patient registry:	
Diagnosis:	
Patient ID: (assigned by patient registry)	Patient ID: (assigned by donor registry)
Date of birth: (YYYY-MM-DD)	

PATIENT HLA			
Locus:	**First value:**	**Second value:**	**Testing method:**
A			☐ DNA-SSP ☐ DNA-SSO ☐ DNA-SBT ☐ Other:
B			☐ DNA-SSP ☐ DNA-SSO ☐ DNA-SBT ☐ Other:
C			☐ DNA-SSP ☐ DNA-SSO ☐ DNA-SBT ☐ Other:
DRB1			☐ DNA-SSP ☐ DNA-SSO ☐ DNA-SBT ☐ Other:
DRB3/4/5			☐ DNA-SSP ☐ DNA-SSO ☐ DNA-SBT ☐ Other:
DQA1			☐ DNA-SSP ☐ DNA-SSO ☐ DNA-SBT ☐ Other:
DQB1			☐ DNA-SSP ☐ DNA-SSO ☐ DNA-SBT ☐ Other:
DPA1			☐ DNA-SSP ☐ DNA-SSO ☐ DNA-SBT ☐ Other:
DPB1			☐ DNA-SSP ☐ DNA-SSO ☐ DNA-SBT ☐ Other:

HLA TYPING REQUEST					
Donor ID:					
A	☐ ▼	☐ ▼	☐ ▼	☐ ▼	☐ ▼
B	☐ ▼	☐ ▼	☐ ▼	☐ ▼	☐ ▼
C	☐ ▼	☐ ▼	☐ ▼	☐ ▼	☐ ▼
DRB1	☐ ▼	☐ ▼	☐ ▼	☐ ▼	☐ ▼
DRB3/4/5	☐ ▼	☐ ▼	☐ ▼	☐ ▼	☐ ▼
DQA1	☐ ▼	☐ ▼	☐ ▼	☐ ▼	☐ ▼
DQB1	☐ ▼	☐ ▼	☐ ▼	☐ ▼	☐ ▼
DPA1	☐ ▼	☐ ▼	☐ ▼	☐ ▼	☐ ▼
DPB1	☐ ▼	☐ ▼	☐ ▼	☐ ▼	☐ ▼

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Patient name:	
Patient registry:	
Diagnosis:	
Patient ID: (assigned by patient registry)	Patient ID: (assigned by donor registry)
Date of birth: (YYYY-MM-DD)	

Comments:

Requesting institution:	**Invoice(s)** to be sent to:
Institution:	Institution:
Address:	Address:
ZIP code:	ZIP code:
City:	City:
Country:	Country:
Attention:	Attention:
Phone:	Phone:
Fax:	Fax:
E-mail:	E-mail:

Person completing form:	Date: (YYYY-MM-DD)	Signature: