Welsh Bone Marrow Donor Registry (WBMDR)

Welsh Transplantation & Immunogenetics Laboratory, Welsh Blood Service, Pontyclun CF72 9WB, Wales, U.K.
Telephone: +44(0)1443 622177. Fax: +44(0)1443 622176. e-mail: wbmdr@wales.nhs.uk

WBM-831 Rev 29/03/2019

BLOOD SAMPLE REQUEST FOR CONFIRMATORY TYPING

Patient name:		Patient ID number: (assigned by patient's registry)		
Transplant center:		Patient ID number: (assigned by donor's registry)		
Date of birth: (Day/Month/Year)	Gender:	Weight: kg	CMV:	Blood Group:

PATIENT HLA TYPING RESULTS:

	A	B	C	DRB1	DQB1
First antigen/allele:					
Second antigen/allele:					

DONOR ID (s)

BLOOD SAMPLE REQUIREMENTS (recommended maximum - 50 ml – please provide clinical reasons for greater volumes)

X 6MLS	MLS EDTA	ACCEPTABLE DAYS OF THE WEEK TO RECEIVE SAMPLES: (CIRCLE ALL THAT APPLY)
x 6mls	mls Heparin	
x 9mls	mls ACD	
x 9mls	mls Clotted	MONDAY / TUESDAY / WEDNESDAY / THURSDAY / FRIDAY
	mls ___________	

DISCLAIMER: The cell products collected from the donor are intended solely for the purpose of diagnostic testing on behalf of the above mentioned patient. No other use is permissible. Excess blood volume is allowed for quality control testing only but not for research purposes. Any portion of the cells not used for the intended testing must be disposed of properly. By accepting these cells, the transplant physician also accepts these terms and conditions. Requests for deviations from these terms must be submitted in writing to the donor registry for approval.

Courier Service: CT samples will automatically be shipped using a courier service chosen by the donor center. The fees for this CT sample are based on the use of this courier service. If you prefer that the samples be shipped using a specific courier service, please list that courier service below. Additional fees may be applied.

Preferred courier service: ___________________________________

Samples to be shipped to: Institution: Address: Attention:	**Invoice(s)** to be sent to: Institution: Address: Attention:
Phone no:	Phone no:
Fax no:	Fax no:
Email:	Email:

Transplant center representative: **<@USER@>**	Signature:	Date: (Day/Month/Year)