

WELSH TRANSPLANTATION AND IMMUNOGENETICS LABORATORY

HLA & DISEASE ASSOCIATION REQUEST FORM



ALL fields marked * MUST be completed.
ALL samples and forms MUST have at least 3 points of identification
and the date of sample collection.
SAMPLES WHICH ARE NOT LABELLED CORRECTLY WILL BE DISCARDED

Patient Details (<i>Addressograph labels are acceptable</i>)			
Hospital Number	Address		
*NHS Number			
*Surname			
* Forename			
*Date of Birth	Gender		
D D M M Y Y Y Y	Postcode		
*Consultant / GP Details			
Name			
Department / Surgery			
Hospital			
Copy of report to			
*Tests Requested			
HLA-B27 <input type="checkbox"/>	Clinical details:		
HLA-B*57:01 (Abacavir hypersensitivity) <input type="checkbox"/>			
Other HLA-Disease Association <input type="checkbox"/> <i>(Please specify HLA antigen/s of interest)</i>			
High Risk Sample <input type="checkbox"/>			
Sample Requirements			
5mls EDTA			
Tests Requested by	Samples Collected by		
Name (<i>Please print</i>)	Name (<i>Please print</i>)		
Signature	Signature		
Date	Contact No.	*Date	Time
D D M M Y Y Y Y		D D M M Y Y Y Y	

Address samples to: Welsh Transplantation and Immunogenetics Laboratory,
 Welsh Blood Service, Ely Valley Road, Talbot Green, Pontyclun. CF72 9WB

Enquiries: Patient Services, Welsh Transplantation and Immunogenetics Laboratory.
 Telephone: 01443 622186/179 (WHTN:01797 2186/2179)
 Email: WTAILRenal@wales.nhs.uk Fax: 01443 622309 (WHTN:01797 2309)