WELSH TRANSPLANTATION AND IMMUNOGENETICS LABORATORY

HLA-TYPING REQUEST FORM - BMT

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

Personal Details		
* Sample Date D D M M Y Y	Hospital Number	NHS Number
*Surname		Address
* Forename		
*Date of Birth D D M M Y Y Y Y	Sex M / F	Postcode

CLINICAL DETAILS

If this sample is from a relative of a potential BMT patient please provide the following recipient details

*Surname	*Forename
*Hospital Number	*Relationship
*Date of Birth D D M M Y Y Y Y	

Consultant / GP Details
Name
Department / Surgery
Hospital
Copy of report to

Tests Requested by		Samples Collected by	
Name *(Please print)*		Name *(Please print)*	
Signature		Signature	
Date D D M M Y Y Y Y	Contact No.	Date D D M M Y Y Y Y	Time

Enquiries:

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