



S20

REQUEST FOR EXTENDED DONOR HLA TYPING

 Urgent request

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

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:

PATIENT HLA			
Locus:	First value:	Second value:	Testing method:
A			<input type="radio"/> DNA-SSP <input type="radio"/> DNA-SSO <input type="radio"/> DNA-SBT
			<input type="radio"/> Other:
B			<input type="radio"/> DNA-SSP <input type="radio"/> DNA-SSO <input type="radio"/> DNA-SBT
			<input type="radio"/> Other:
C			<input type="radio"/> DNA-SSP <input type="radio"/> DNA-SSO <input type="radio"/> DNA-SBT
			<input type="radio"/> Other:
DRB1			<input type="radio"/> DNA-SSP <input type="radio"/> DNA-SSO <input type="radio"/> DNA-SBT
			<input type="radio"/> Other:
DRB3/4/5			<input type="radio"/> DNA-SSP <input type="radio"/> DNA-SSO <input type="radio"/> DNA-SBT
			<input type="radio"/> Other:
DQA1			<input type="radio"/> DNA-SSP <input type="radio"/> DNA-SSO <input type="radio"/> DNA-SBT
			<input type="radio"/> Other:
DQB1			<input type="radio"/> DNA-SSP <input type="radio"/> DNA-SSO <input type="radio"/> DNA-SBT
			<input type="radio"/> Other:
DPA1			<input type="radio"/> DNA-SSP <input type="radio"/> DNA-SSO <input type="radio"/> DNA-SBT
			<input type="radio"/> Other:
DPB1			<input type="radio"/> DNA-SSP <input type="radio"/> DNA-SSO <input type="radio"/> DNA-SBT
			Other:



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 Urgent request

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

HLA TYPING REQUEST DONOR 1,2,3		
Donor ID:		
GRID:		
A <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DRB1 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DRB3/4/5 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DQA1 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DQB1 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DPA1 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DPB1 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HLA TYPING REQUEST DONOR 4,5		
Donor ID:		
GRID:		
A <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DRB1 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DRB3/4/5 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DQA1 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DQB1 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DPA1 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DPB1 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

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