

ADTL-FR-030

ANKARA HLA TYPING LABORATORY TEST REQUEST FORM

Request Date/Time									
Recipient				Donor					
Barcod				Barcod					
Protocol No				Protocol No					
Adress				Adress					
Birthdate/...../.....			Birthdate/...../.....				
Gender	Man <input type="checkbox"/> Woman <input type="checkbox"/>			Gender	Man <input type="checkbox"/> Woman <input type="checkbox"/>				
Blood Type				Blood Type					
Contact Informations				Contact Informations					
Sample Type	Whole Blood (EDTA)	<input type="checkbox"/>	Buccal Mucosa	<input type="checkbox"/>	Sample Type	Whole Blood (EDTA)	<input type="checkbox"/>	Buccal Mucosa	<input type="checkbox"/>
	Other					Other			
Diagnosis				Kinship Relationship With The Recipient					
The Date of the Last Transfusion/...../.....								
Has There Been a Transplant Before?	Yes <input type="checkbox"/> No <input type="checkbox"/>								
Test Code/Name									
<input type="checkbox"/>	C8389606/SBT, High Resolution, 4-digits, HLA Typing, 6 loci (HLA A, B, C, DR, DQ, DP)								
<input type="checkbox"/>	C8696183/SBT, High Resolution, 4-digits, HLA Typing, 5 loci (HLA A, B, C, DR, DQ)								
Requesting Physician									
Institution/Duty				Stamp/Signature					
Behalf of Ankara Tissue Typing Laboratory									
Example Accepted Date/Time				Signature/Stamp Accepting the Sample					