Pathkind Labs

HLA TYPING REQUISITION FORM FOR BONE MARROW TRANSPLANT- (Form-16)

Hematopoietic Stem Cell Transplantation

Referring Doctor's information

Referring Doctors name: ....

Email address: .... Mobile number..

Name of Hospital: ....

Test requested (Please tick in ☐ below)

HLA typing low resolution for ☐ -A locu ☐ -B locus, ☐ -C locus, ☐ -DRB1 locus, ☐ -DQB1 locus,-DPB1 locus.

HLA typing High resolution (NGS) for -A, -B, -C, -DRB1, -DQB1 loci ☐.

RECIPIENT & DONOR DETAILS:

	PATIENT	DONOR 1	DONOR 2	DONOR 3
Name				
Date of birth				
Gender				
Relationship to patient				
Previous HLA typing result (if available)	If attached	If attached	If attached	If attached
Type of sample	EDTA	EDTA	EDTA	EDTA
Date & Time of sample collection				

Signature & Name of phlebotomist **Signature & Name of doctor**

Clinical details of Patient/Recipient.

For hemapoietic stem all transplant

Clinical Diagnosis ....

History of blood or component transfusion		Transfusion Type: Whole Blood ☐ Packed cells ☐ Plasma ☐ Platelet ☐
History of infection in patient(if any)	HIV ☐ Hepatitis B ☐ Hepatitis C ☐ Others Specify......................................	

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