



Marrow Donor Program Belgium - Registry
Motstraat 40 2800 Mechelen
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Email : MDPB-registry@rodekruis.be

BLOOD SAMPLE REQUEST FOR VERIFICATION (CONFIRMATORY) TYPING

Patient name:	Patient ID number: (assigned by patient's registry)
Transplant center:	Patient ID number: (assigned by donor's registry)
Date of birth: (Day/Month/Year)	Gender: <input type="checkbox"/> M <input type="checkbox"/> F

PATIENT HLA TYPING RESULTS:

	A	B	C	DRB1	DQB1
First antigen/allele:					
Second antigen/allele:					

DONOR(S):

Donor from registry:	<input type="checkbox"/> URGENT REQUEST
Donor ID:	

BLOOD SAMPLE REQUIREMENTS: (recommended max: 50 ml. Please provide clinical reasons for greater volumes)

mls EDTA	ACCEPTABLE DAYS OF THE WEEK TO RECEIVE SAMPLES: <input type="checkbox"/> MONDAY / <input type="checkbox"/> TUESDAY / <input type="checkbox"/> WEDNESDAY / <input type="checkbox"/> THURSDAY / <input type="checkbox"/> FRIDAY
mls Heparin	
mls ACD	
mls Clotted	
mls	
DISCLAIMER: The cell products collected from the donor are intended solely for the purpose of diagnostic testing on behalf of the above mentioned patient. No other use is permissible. Excess blood volume is allowed for quality control testing only but not for research purposes. Any portion of the cells not used for the intended testing must be disposed of properly. By accepting these cells, the transplant physician also accepts these terms and conditions. Requests for deviations from these terms must be submitted in writing to the donor registry for approval.	
Courier Service: CT samples will automatically be shipped using a courier service chosen by the donor center. The fees for this CT sample are based on the use of this courier service. If you prefer that the samples be shipped using a specific courier service, please list that courier service below. Additional fees may be applied.	
Preferred courier service:	

Samples to be shipped to: Institution: Address: Attention: Phone no: Fax no: Email:	Invoice(s) to be sent to: Institution: Address: Attention: Phone no: Fax no: Email:
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Transplant center representative:	Signature:	Date: (Day/Month/Year)
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