



CORD BLOOD SAMPLE REQUEST

PATIENT DATA:

Patient name:	Patient ID number: (assigned by patient's registry)
Patient 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:

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

CORD BLOOD IDENTIFICATION:

Cord ID:	Cord from registry:				
	A	B	C	DRB1	DQB1
First antigen/allele:					
Second antigen/allele:					

DNA SAMPLE REQUIREMENTS:

<input type="checkbox"/> ml Cord blood plasma (stored at -80°C) <input type="checkbox"/> ml Cord blood DNA <input type="checkbox"/> cells Cord blood cells (stored in liquid nitrogen) <input type="checkbox"/> ml Maternal serum (stored at -80°C) <input type="checkbox"/> cells Maternal cells or DNA (stored in liquid nitrogen or at -80°C) <input type="checkbox"/> ml Maternal plasma (ambient) <input type="checkbox"/> ml Other:	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 Preferred dates of shipment: <input type="checkbox"/> URGENT REQUEST
Precautions regarding the sample: <input type="checkbox"/> Ambient temperature <input type="checkbox"/> Wet ice (4°C)	<input type="checkbox"/> Dry ice <input type="checkbox"/> Dry shipper
<p>Courier Service: DNA samples will automatically be shipped using a courier service chosen by the Cord Blood Bank. The fees for this DNA 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:</p>	



Marrow Donor Program Belgium – Registry
Motstraat 40 2800 Mechelen
Tel: (32) - 15 44 33 96 Fax: (32) - 15 44 36 56
Email : MDPB-registry@rodekruis.be

CORD BLOOD SAMPLE REQUEST

Samples to be shipped to: Institution: Address:	Invoice(s) to be sent to: Institution: Address:
Contact name:	Contact name:
Phone no:	Phone no:
Fax no:	Fax no:
Email:	Email:

Transplant center representative:	Signature:	Date (Day/Month/Year):
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