



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

REQUEST FOR FURTHER DNA BASED DONOR TYPING

PATIENT DATA:

Patient name:	Patient ID number: (assigned by patient's registry)
Patient registry:	Patient ID number: (assigned by donor's registry)
Diagnosis:	Date of birth: (Day/Month/Year)

PATIENT HLA: (Typing methodology used:)

A	B	C	DRB1	DRB3	DRB4	DRB5	DQB1	DPB1	DQA1	DPA1

PLEASE SPECIFY THE DNA TYPING REQUESTED:

Donor from registry:	<input type="checkbox"/> URGENT REQUEST									
<input type="checkbox"/> Low Resolution:			<input type="checkbox"/> Intermediate Resolution:							
Donor ID:	A	B	C	DRB1	DRB3	DRB4	DRB5	DQB1	DPB1	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> High Resolution:										
Donor ID:	A	B	C	DRB1	DRB3	DRB4	DRB5	DQB1	DPB1	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

REQUESTING CENTER:

Hospital:	Contact name:
Address:	Phone no:
	Fax no:
	E-mail:

INVOICE ADDRESS: (to whom request for payment will be sent)

Institution:	Contact name:	
Address:	Phone no:	
	Fax no:	
	E-mail:	
Person Completing Form:	Signature:	Date: (Day/Month/Year)