SEATTLE CANCER CARE ALLIANCE
Fred Hutchinson Cancer Research Center
University of Washington
Children's Hospital & Regional Medical Center

CLINICAL IMMUNOGENETICS LABORATORIES
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REQUISITION FOR HLA TESTING

This page must be completed and returned with each person's blood samples.
All blanks must be completed.

Person from whom blood is being drawn:
(Full Name Required)

Last: ____________________ **First:** __________________ **Middle:** ____________ **Suffix:** ______

Date of Birth: _________ **Gender:** M __ F __ **Date sample drawn**: ____________________

Home phone: (optional) ________________ Work phone: (optional) _________________

Relationship to potential recipient: ______________________

If blood is being drawn from someone <18 years old - name of Legal Guardian.

Name: ____________________________ **Relationship:** ________________________________

Potential Transplant Recipient name:

Last: ________________________ First: ______________________ M.I.: _____ Suffix: _________

Diagnosis: ____

Referring MD: Print ____

MD Phone: _________________ MD Address: ___________________________________

Phlebotomist/LAB collecting sample: **Sample source □ Blood or □ Buccal Swabs**

- I have verified the above person's identification. I have also labeled **each tube** with this person's full name, date of birth, date drawn, patient number (if available) and my initials.

If patient sample being collected Drug therapy statement: - date of last treatment.				
Rituximab:	IVIG:	Campath:	Thymoglobulin:	Other:

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Your Name-Print: __________________________ Signature: ______________________________

Phone number: ____

Name of Institution sample drawn at: ____

City: _________________________________ State: ______________________________

NOTE: Missing or incomplete information may delay testing or reporting