agence de la Biomédecine

BLOOD SAMPLE REQUEST

PATIENT	Last name: _____ *(3 first letters)* First name: _____ *(3 first letters)* Patient ID: _____ Int. Registry: _____

DONOR	Donor ID: _____ GRID: _____ Int. Registry: France Greffe de Moelle

Date of request: ____/____/____

PATIENT'S HLA TYPING

A* ___:_____:_____:_____ __ B* ___:_____:_____:_____ __ C* ___:_____:_____:_____ __	A* ___:_____:_____:_____ __ B* ___:_____:_____:_____ __ C* ___:_____:_____:_____ __
DRB1* ____:_____:___:___ __ DRB3* ____:_____:___:___ __ DRB4* ____:_____:___:___ __ DRB5* ____:_____:___:___ __ DQB1* ____:_____:___:___ __ DPB1* _____:_____:___:___	DRB1* ____:_____:___:___ __ DRB3* ____:_____:___:___ __ DRB4* ____:_____:___:___ __ DRB5* ____:_____:___:___ __ DQB1* ____:_____:___:___ __ DPB1* _____:_____:___:___

BLOOD REQUIREMENTS *(max. 50 mls)*

_____ X 7 mls EDTA _____ X 7 mls ACD _____ X 7 mls Heparin _____ X 7 mls clotted blood	Remarks: _____

SHIPPING ADDRESS *(in block letters)*

Name: _____ Tel n°: +_____

Address: _____ Fax n°: +_____

_____

_____

_____

Comments: _____

Name: _____ Signature:

(person completing the form)

Request to be sent to:

FRANCE GREFFE DE MOELLE Registry
Fax: +33-1-49 98 38 71 *or*
E-mail: coordination.fgm@biomedecine.fr

WMDA Accredited