agence de la biomédecine

DONOR TYPING REQUEST

PATIENT	Last name: ____________ (first 3 letters) First name: __________ (first 3 letters)
	Patient ID: ______________________________
	Int. Registry: ______________________________

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

PATIENT - HLA TYPING

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

DONOR - ABDR HLA TYPING

A ___:_______	B ___:_______	C ___:_______	DR ___:_______	DQ ___:_______
A ___:_______	B ___:_______	C ___:_______	DR ___:_______	DQ ___:_______

❑ Please split the following antigen(s): A _____ A _____
B _____ B _____

❑ Please define the following HLA typing:

❑ A	❑ LR	❑ HR
❑ B	❑ LR	❑ HR
❑ Cw	❑ LR	❑ HR
❑ DR		❑ LR *(for AB typed donor)*
★ ❑ DRB1		❑ HR ★ *B3/B4, B5 included*
❑ DQB1		❑ HR
❑ DPB1		❑ HR

Person completing the form: ______________________________

Date of request: ______/______/______ *(dd/mm/yy)*

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