HLA TYPING REQUEST

To:	

Patient:	
Name:	
Date of Birth:	
Patient Registry:	

Patient's HLA Typing					
Class – I			Class - II (low resolution)		
A	B	C	DR	DRw	DQ
Class – II (high resolution)					
DRB1	DRB3	DRB4	DRB5	DQB1	DPB1

Donor Identification(s)

Loci to be Typed	
HLA – A (Intermediate resolution)	
HLA – B (Intermediate resolution)	
HLA – C (Intermediate resolution)	
HLA – DR Intermediate resolution)	
HLA – DQ (Intermediate resolution)	
HLA – A (High resolution)	
HLA – B (High resolution)	
HLA – C (High resolution)	
HLA – DR (High resolution)	
HLA – DQ (High resolution)	

Invoice Address

Date: _____/_____/_____

Signature: _____

IMP.74.276.01

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