BLOOD SAMPLE REQUEST FOR CONFIRMATORY TYPING

Last Name	
First Name	
Date of Birth	
Gender	
Diagnosis	

Patient Registry

CEDACE ID Code

Patient HLA Typing

A*	B*	C*	DRB1*	DRB* 3/4/5	DQB1*	DPB1*
A*	B*	C*	DRB1*	DRB* 3/4/5	DQB1*	DPB1*

Acceptable days of the week: Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐

Remarks: ____

Identification numbers of donors

Blood Requirements	
__________ mls EDTA	________ Mls Heparin
__________ mls ACD	________ Mls Clotted Blood

Notification of blood samples arrival: __________ days

Delivery Address	**Invoice Address**
	Centro de Sangue e Transplantação de Lisboa – Área da Transplantação - CEDACE Alameda das Linhas de Torres, nº 117 1769-001 Lisboa Portugal

Date: _____/_____/_____ Signature: ______________________________

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