EUROCORD-SLOVAKIA

Eurocord -Slovakia, Slovak Placental Stem Cell Registry
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CBU TESTING OR CBU TYPING REQUEST

PATIENT DATA:

Patient ID number: (assigned by patient's registry)	Date of birth: (Day/Month/Year)
Diagnosis:	

PATIENT HLA: (Typing methodology used :_____)

A	B	C	DRB1	DRB3	DRB4	DRB5	DQB1	DPB1	DQA1	DPA1

PLEASE SPECIFY REQUESTED DNA TYPING: **CBU ID:**

☐ **Low Resolution** ☐ **Intermediate Resolution** ☐ **High Resolution**

A	B	C	DRB1	DRB3	DRB4	DRB5	DQB1	DPB1	DQA1	DPA1
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

PLEASE SPECIFY REQUESTED IDM TESTS: **CBU ID:**

HCV		☐ **serological**	☐ **NAT**	**EBV**	☐ **serological**	☐ **NAT**	
HBV	☐ **anti HBsAg**	☐ **anti HBc tot**	☐ **NAT**	**Syphilis**	☐ **RPR**	☐ **TPPA**	
HIV	☐ **anti HIV 1/2**	☐ **p24Ag**	☐ **NAT**	**Other:**			
CMV		☐ **serological**	☐ **NAT**	**Other:**			
Toxoplasmosis		☐ **serological**	☐ **NAT**	**Other:**			

PLEASE SPECIFY OTHER REQUESTED TESTS: **CBU ID:**

1.
2.
3.

REQUESTING CENTER: (to whom report will be sent)

Hospital: Address:	Contact name: Phone no: Fax no: E-mail:

INVOICE ADDRESS: (to whom request for payment will be sent)

Address:	Contact name: Phone no: Fax no: E-mail:	
Person Completing Form:	Signature:	Date: (Day/Month/Year)