HISTOCOMPATIBILITY TESTING REQUEST FORM

Each specimen MUST be clearly labelled with FULL name and DOB and either Hospital Number or NHS number. Samples cannot be accepted without the following information in full.

UKAS MEDICAL 8630

Accredited

ANTHONY NOLAN saving the lives of people with blood cancer

By completing this request form, you confirm the following:

1. you have complied with the requirements as set out in this form, the Anthony Nolan Testing Services terms and conditions and where appropriate, Anthony Nolan's Histocompatibility Laboratories Service Provision User Guide;
2. you have obtained the appropriate patient or donor informed consent as applicable, and all other permissions required in accordance with all applicable law and regulation and guidelines or otherwise in order to permit the conduct of testing you have requested on the samples; and

subject to acceptance by Anthony Nolan, you agree to be bound by the Anthony Nolan Testing Services terms and conditions available to view on our website at https://www.anthonynolan.org/sites/default/files/Terms_and_Conditions_for_Testing_Services.pdf, to the exclusion of all other terms and conditions (including any which you purport to apply subsequent to submission of this form).

PATIENT/DONOR DETAILS

First Name		Family Name			
Date of Birth		Hospital Number (if applicable)		NHS Number (if applicable)	
Gender		Ethnicity			
Transplant/ Requesting Centre		Contact details for whom the results are to be sent			

Sample Type (Please tick) ☐Blood ☐DNA ☐Saliva Kit ☐Buccal Swab ☐Other

COLLECTION DETAILS

Date		Time		By	
Transplant Date		Treatment Start Date			

PATIENT ONLY

Please provide the information below

Diagnosis		Date of Diagnosis		Current WBC	X10^9/l (if known)
Patient transfused in the last 7 days?	☐Yes (Please provide details)	☐No		NHS/Private Patient)	NHS☐ PRIVATE☐

DETAILS OF PATIENT RELATED TO DONOR ABOVE (IF APPLICABLE)

Please provide the information below

First Name		Family Name		DOB	
Hospital/NHS Number		Relationship of Donor to Patient			

IF URGENT PROCESSING IS REQUIRED, PLEASE EMAIL: clinicalservices@anthonynolan.org

TEST REQUESTED

Initial OR Confirmatory HLA typing ☐
HLA typing plus CMV testing and ABO blood grouping
2 x 4ml tubes of venous blood taken into EDTA and 1x 4ml tube clotted

Antibody screening / Identification ☐
Recommended for patients prior to HLA mismatched transplants only.
1 x 10ml clotted sample from the patient

Forward blood **immediately** to the laboratory at the address above marked FAO **Clinical Services**. We can receive blood Mondays-Fridays ex 8am-5pm excluding bank holidays in England and Wales.

Please refer to our privacy policy (www.anthonynolan.org/privacy-policy) for further information on how Anthony Nolan uses and stores personal information.

THIS SECTION MUST BE COMPLETED IN FULL

Name of Invoicee		Ref no:	
Address of Invoicee			

FOR LAB USE ONLY

Patient Number		Sample number	
Date / Time Received		Received By	

ATTACH LABEL HERE

ANTHONY NOLAN HISTOCOMPATIBILITY LABORATORIES:
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