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| 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/clinicians-and-researchers/transplant-and-laboratory-services/transplantation-services/guides-and-forms>, 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 | |  | | | |
|  |  | | | | |  | | NHS Number | |  | |
| Date of Birth |  | | | Hospital Number  (if applicable) | |  | | NHS Number  (if applicable) | |  | |
|  |  | | |  | |  | |  | |  | |
| Gender |  | | | Ethnicity | |  | | Patient Type Adult Teen & Young Adult Paediatric | | | | |
| vvvv |  | | |  | | |  | |  | |  | | |
| 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 | |  | |

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| --- | --- | --- | --- |
| Transplant Date |  | Treatment Start Date |  |

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| **PATIENT ONLY** | **Please provide the information below** | | | | | | |
| Diagnosis |  | Date of Diagnosis |  | | Current WBC | X109/I (if known) | |
|  |  |  |  | |  |  | |
| Patient transfused in the last 7 days? | Yes  (Please provide details) | | | No | NHS/Private Patient) | NHS | PRIVATE |

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| **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**

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| --- | --- | --- | --- |
| **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***](https://www.anthonynolan.org/privacy-policy)[***(www.anthonynolan.org/privacy-policy)***](https://www.anthonynolan.org/privacy-policy) ***for further information on how Anthony Nolan uses and stores personal information.***

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| --- | --- | --- | --- | --- | --- |
| **THIS SECTION MUST BE COMPLETED IN FULL** | | Name of Invoicee |  | Ref no: |  |
|  | |  |  |  |  |
| Address of Invoicee |  | | | | |

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| --- | --- | --- | --- | --- |
| **FOR LAB USE ONLY** |  |  |  |  |
| Patient / Donor Number |  | Sample number |  |
|  |  |  |  |
| Date / Time Received |  | Received By |  |