

Tel (937) 461-3295 Fax (937) 461-2738

PATIENT/DONOR INFORMATION				
Name (Last, First):		ID:	DOB:	Sex: Race:
Donor for:/ NA	Relationship to Pt:/ NA	Physician:		Institution:
Diagnosis:		<input type="checkbox"/> Diagnostic <input type="checkbox"/> HLA Selected Platelets <input type="checkbox"/> Other		
If Abnormal: WBC Count	% Lymphocyte			
Sample Collection	Date:	Time:	Collected by:	

MINIMUM SAMPLE REQUIREMENTS	
HLA- B27	10 ml Sodium Heparin DO NOT REFRIGERATE
DNA Typing	7ml EDTA
Antibody ID	10 ml Plain Red Top (<u>Serum Separator Tubes are NOT acceptable</u>) or 5 ml EDTA

Contact Hospital Services (937) 461-7557 for specimen pickups

Samples will NOT be accepted after 12:00 Noon on Fridays without prior approval

Samples should be received within 24 hours of collection

TEST REQUESTED	
<input type="checkbox"/> HLA-B27 serologic (701, 729)	<input type="checkbox"/> DNA-A,B,C (Class I)(753)
<input type="checkbox"/> DNA-B27 (754)	<input type="checkbox"/> DNA-DR,DR345 (Class II)(751)
<input type="checkbox"/> TRALI Workup (728)	<input type="checkbox"/> DNA-DQ (Class II)(723)
<input type="checkbox"/> Other	<input type="checkbox"/> DNA-Single Locus- A B C(754)
Comments:	

HLA Laboratory Use ONLY

Received: Date:	Time:	By:	Volume:	Log #:
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