TRANSPLANTATION IMMUNOLOGY UNIT
ALLERGY AND IMMUNOLOGY RESEARCH CENTRE
INSTITUTE FOR MEDICAL RESEARCH
JALAN PAHANG, 50588 KUALA LUMPUR
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HLA ANTIBODY TEST REQUEST FORM (PRA/DSA)

HOSPITAL : TEL. NO. :
WARD : FAX NO. :
☐ PAYING ☐ FREE

Patient's Details

Name :
I.C. No. / Passport No. :
Age / Gender / Ethnic :

For Solid Organ Transplant Only (MUST BE FILLED IN)

1. CLINICAL HISTORY
Primary cause of ESRD / CKD ☐ Diabetes ☐ Hypertension ☐ SLE ☐ IgAN ☐ FSGS
☐ Kidney stone ☐ Others (*Please specify*):

2. STATUS OF TRANSPLANT
☐ PRE-TRANSPLANT
☐ Deceased Donor Waiting List
☐ Living-related (Donor's name) :
Planned Date of Transplant : *(If available)*

☐ POST-TRANSPLANT
Donor's Name :
Donor's Family No. :
Date of Transplant :

For Solid Organ Transplant and HSCT (Where Applicable)

3. SENSITIZING EVENTS
☐ Last Blood Transfusion Date : (*dd/mm/yyyy*)
☐ Pregnancy / Miscarriage No. of Pregnancy :
Last Delivery Date : (*mm/yyyy*)
☐ Previous Transplant Date of Transplant : (*mm/yyyy*)
Donor's Name :
Donor's Family No. :

4. TREATMENT GIVEN

	Last Treatment Date		Last Treatment Date
☐ ATG	:	☐ DFPP	:
☐ Rituximab	:	☐ IvIg	:

1. Please collect **6 mL of whole blood** in plain tube.
2. Please seal the tube stopper to avoid leakage of blood during transportation.
3. Transport condition: Room Temperature (**WITHOUT ICE**).
4. Blood samples must reach the lab by 10.30 am.

Time blood collected:
Date blood collected:

For IMR Laboratory Use Only

Received Stamp:

	Patient
Lab. No.	
DNA No.	
Volume / Quantity	
Sample Condition	☐ Good ☐ Others:

Received By:

Test requested by:

Signature :
Name :
Stamp :

Date :

Note: ***The full name, stamp and signature of the Medical Officer requesting the test MUST be provided. The date and test requested MUST be provided.***