TRANSPLANTATION IMMUNOLOGY UNIT
ALLERGY AND IMMUNOLOGY RESEARCH CENTRE
INSTITUTE FOR MEDICAL RESEARCH
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HLA TYPING TEST REQUEST FORM (DISEASE ASSOCIATION)

☐ **B*27** ☐ **B*15:02**

☐ **B*57:01** ☐ **Others ( )**

HOSPITAL :
WARD :

TEL. NO. :
FAX NO. :
☐ PAYING ☐ FREE

Patient's Details

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

1. This test is done **ONLY by appointment**.
2. Please collect **6 mL of EDTA blood** and mix well.
3. Please seal the tube stopper to avoid leakage of blood during transportation.
4. Transport condition: Room Temperature (**WITHOUT ICE**).
5. Blood samples must reach the lab by 10.30 am.

Time blood collected:
Date blood collected:

Test requested by:

Signature :
Name :
Stamp :

Date :

For IMR Laboratory Use Only

Received Stamp:

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

Received By:

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.***