TRANSPLANTATION IMMUNOLOGY UNIT
ALLERGY AND IMMUNOLOGY RESEARCH CENTRE
INSTITUTE FOR MEDICAL RESEARCH
JALAN PAHANG, 50588 KUALA LUMPUR
DIRECT LINE: 03-2616 2581 TEL: 03-2616 2666 FAX: 03-2691 2019

HLA CROSSMATCH TEST REQUEST FORM (LIVING DONOR)

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

	RECIPIENT	DONOR
Name:		
I.C. No. / Passport No.:		
Age / Gender / Ethnic:		
Relationship to Recipient:	- N/A -	
Planned Date of Transplant (*If available*):		

Clinical History

Primary cause of ESRD / CKD	□ Diabetes	□ Hypertension	□ SLE	□ IgAN	□ FSGS
	□ Kidney stone	□ Others (*Please specify*):			
		Last Treatment Date		Last Treatment Date	
Treatment Given	□ ATG	:	□ DFPP	:	
	□ Rituximab	:	□ IvIG	:	

Test Method (*Please select*)	**RECIPIENT**	**DONOR**
□ Complement-Dependent Cytotoxicity (CDC-XM)	6 mL blood (Plain tube)	18 mL blood (Sodium Heparin tube)
□ Flow Cytometry (FC-XM)	6 mL blood (Plain tube)	18 mL blood (Sodium Heparin tube)

Time blood collected:
Date blood collected:

Test requested by:

Signature :
Name :
Stamp :

Date :

1. This test is done **ONLY by appointment from Monday to Thursday.**
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.

For IMR Laboratory Use Only

Received Stamp:

	Recipient	Donor
Lab. No.		
Volume / Quantity		
Sample Condition	□ Good □ Others:	□ 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.***