TRANSPLANTATION IMMUNOLOGY UNIT
ALLERGY AND IMMUNOLOGY RESEARCH CENTRE
INSTITUTE FOR MEDICAL RESEARCH
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HLA CROSSMATCH TEST REQUEST FORM (DECEASED DONOR)

HOSPITAL : WARD :

	DONOR	RECIPIENT 1	RECIPIENT 2	RECIPIENT 3	RECIPIENT 4
Name:					
I.C. No. / Passport No.:					
Age / Gender / Ethnic:					
Referred Hospital:					

Time blood collected:

Date blood collected:

Test requested by:

Signature :

Name :

Stamp :

Date :

1. Please collect **9 mL x 16 tubes of blood** in **Sodium Heparin tube from donor** and mix well.
2. Please collect a minimum of **6 mL of blood in plain tube from potential recipient.**
3. Please seal the tube stopper to avoid leakage of blood during transportation.
4. Transport condition: Room Temperature (**WITHOUT ICE**).

For IMR Laboratory Use Only

Received Stamp:		DONOR	RECIPIENT 1	RECIPIENT 2	RECIPIENT 3	RECIPIENT 4
	Lab. No.					
	DNA No.					
	Volume / Quantity					
	Sample Condition	☐ Good ☐ Others:	☐ Good ☐ Others:	☐ Good ☐ Others:	☐ Good ☐ Others:	☐ Good ☐ Others:
	PRA Status (*Past 3 months only*)	- N/A -	☐ Done ☐ Not done Date: Class I : % Class II : %	☐ Done ☐ Not done Date: Class I : % Class II : %	☐ Done ☐ Not done Date: Class I : % Class II : %	☐ Done ☐ Not done Date: Class I : % Class II : %
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.