

TRANSPLANTATION IMMUNOLOGY UNIT
 ALLERGY AND IMMUNOLOGY RESEARCH CENTRE
 INSTITUTE FOR MEDICAL RESEARCH
 NATIONAL INSTITUTES OF HEALTH
 NO 1, JALAN SETIA MURNI U13/52
 SEKSYEN U13 BANDAR SETIA ALAM
 40170 SHAH ALAM, SELANGOR

DIRECT LINE: 03-3362 8383

TEL: 03-3362 7900

FAX: 03-3362 7906

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	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> SLE	<input type="checkbox"/> IgAN	<input type="checkbox"/> FSGS
<input type="checkbox"/> Kidney stone <input type="checkbox"/> Others (<i>Please specify</i>):					
2. STATUS OF TRANSPLANT					
<input type="checkbox"/> PRE-TRANSPLANT			<input type="checkbox"/> POST-TRANSPLANT		
<input type="checkbox"/> Deceased Donor Waiting List			Donor's Name :		
<input type="checkbox"/> Living-related (Donor's name):			Donor's Family No. :		
Planned Date of Transplant: <i>(If available)</i>			Date of Transplant :		

For Solid Organ Transplant and HSCT (Where Applicable)

3. SENSITIZING EVENTS					
<input type="checkbox"/> Last Blood Transfusion	Date	:	<i>(dd/mm/yyyy)</i>		
<input type="checkbox"/> Pregnancy / Miscarriage	No. of Pregnancy	:			
	Last Delivery Date	:	<i>(mm/yyyy)</i>		
<input type="checkbox"/> Previous Transplant	Date of Transplant	:	<i>(mm/yyyy)</i>		
	Donor's Name	:			
	Donor's Family No.	:			
4. TREATMENT GIVEN					
	Last Treatment Date			Last Treatment Date	
<input type="checkbox"/> ATG	:	<input type="checkbox"/> DFPP	:		
<input type="checkbox"/> Rituximab	:	<input type="checkbox"/> IVIg	:		

1. Please collect **6 mL of whole blood** in plain tube.0
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	<input type="checkbox"/> Good <input type="checkbox"/> Others:	
Received By:		

Test requested by:

Signature :
 Name :
 Stamp :
 Date :

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