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 8382 TEL: 03-3362 7900 FAX: 03-3362 7906

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*):			
Treatment Given	☐ ATG	Last Treatment Date :	☐ DFPP	Last Treatment Date :
	☐ 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.		
Family 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.***