A collaboration among the University of Minnesota, University of Minnesota Physicians and Fairview Health Services

IMMUNOLOGY/HISTOCOMPATIBILITY LABORATORY – BMT Request Form

THIS FORM MUST BE COMPLETED AND RETURNED WITH SAMPLES

Please submit separate sheets for recipient and each donor(s)

Samples must be individually labeled with 2 (Two) Identifiers. **Do Not Draw Blood on Friday or Saturday!**

SPECIMEN INFORMATION

COLLECTION DATE	COLLECTION TIME

HLA Typing:

- 7 ml EDTA (purple top)
- Buccal (Mouth) Swab kit
- Immunocompromised patients: Buccal (Mouth) Swab kit

PRA (Antibody)

- 14 ml plain red top (serum)

Minimum Volume (pediatric)

- 3ml plain red top (serum)

BILLING INFORMATION

MUST BE PROVIDED FOR NON REFERRED PATIENTS

LAB/HOSPITAL NAME		
STREET ADDRESS		
CITY	STATE	ZIP CODE
TELEPHONE NO.		

RECIPIENT INFORMATION

NAME LAST FIRST Middle		
STREET ADDRESS		
CITY	STATE	ZIP CODE
BIRTHDATE		
HOSPITAL MRN		
IF UNDER 18, NAME OF LEGAL GUARDIAN		
DIAGNOSIS		

DONOR INFORMATION

NAME LAST FIRST Middle		
STREET ADDRESS		
CITY	STATE	ZIP CODE
BIRTHDATE		
RELATIONSHIP OF DONOR TO RECIPIENT		

FAIRVIEW UNIVERSITY PHYSICIAN (IF REFERRED)

NAME	
DEPARTMENT	
TELEPHONE	UMMC BOX NO

REFERRING PHYSICIAN

NAME		
STREET ADDRESS		
CITY	STATE	ZIP CODE
TELEPHONE	FAX	

- Address and shipping instructions are on the back of this form.
- Questions, call 888-601-0787 (Bone Marrow Transplant Office).