



REQUEST FOR TESTING
Immunogenetics/HLA

HLA-A,B,DRB1: (yes) (no)

Lymphocyt crossmatch : (yes) (no)

COLLECTION DATE:...../...../20... TIME:.....

DIAGNOSIS/PURPOSE OF TESTING:.....

PHYSICIAN OR AUTHORIZED PERSON ORDERING TEST:

SPECIMEN IDENTIFICATION

PATIENT NAME: SEX(M/F): AGE:

DONOR NAME: RELATIONSHIP TO THE PATIENT:

HOSPITAL/INSTITUTION:

CONTACT PERSON: name:..... .. phone number:.....

SEND REPORT TO: name..... e-mail:.....

SEND BILL TO:

NAME:

ADDRESS:

TAX NUMBER:

TAX OFFICE:

COLLECTION TUBES:

10 mL VIOLET TOP (EDTA) AND SERUM FROM PATIENT

10 mL VIOLET TOP (EDTA) FROM DONOR

TRANSMED LAB CONTACT PERSON:

DR.MUSTAFA BALCI PHONE: 0090-532-6538904 FAX: 0090-312-4186660

ADDRESS:

TRANSMED ÖZEL TIP LABORATUVARI

MITHATPASA CADDESİ NO: 58/10

POST CODE:06420 KIZILAY

ANKARA-TÜRKİYE