High Resolution Typing Assistance: Patients and Related Donors

Request Date (MM/DD/YYYY):

Section A: Transplant Center Information	
TC ID:	TC Name:
TC Coordinator:	Email:
Other Coordinator:	Email:

Section B: Patient Information		
Patient name:		
NMDP RID (if available):	DOB (MM/DD/YYYY):	
Patient Race:	Patient Ethnicity:	
If **Other / Multiple Races**, specify:		
(Peds only) Parent/guardian name:		
Address:		
City:	State:	Zip Code:
Phone number:	Email:	

Section C: Patient Insurance	
Insurance type:	
If **Private/Commercial**, company name:	
Issuing State:	Group Number:
Insurance issue:	
If **Other**, explain:	

Section D: Typing Request/s
HLA Typing Assistance is requested for:
Patient only - complete Section E
Related Donor(s) only - complete Section F
Patient *and* Related Donor(s) - complete Sections E and F

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Section E: Patient Information			N/A
Should the patient be given instructions in English or Spanish?		English	Spanish
If patient's mailing address differs from above:			
Address:			
City:	State:	Zip Code:	

Section F: Related Donor Information			N/A
(1) Full Donor name:			
DOB (MM/DD/YYYY):	Relationship to Patient:		
Address:			
City:	State:	Zip Code:	
Phone number:	Email:		
Should the related donor be given instructions in English or Spanish?		English	Spanish

(2)			N/A
Full Donor name:			
DOB (MM/DD/YYYY):	Relationship to Patient:		
Address:			
City:	State:	Zip Code:	
Phone number:	Email:		
Should the related donor be given instructions in English or Spanish?		English	Spanish

(3)			N/A
Full Donor name:			
DOB (MM/DD/YYYY):	Relationship to Patient:		
Address:			
City:	State:	Zip Code:	
Phone number:	Email:		
Should the related donor be given instructions in English or Spanish?		English	Spanish

(4)				N/A
Full Donor name:				
DOB (MM/DD/YYYY):		Relationship to Patient:		
Address:				
City:		State:	Zip Code:	
Phone number:		Email:		
Should the related donor be given instructions in English or Spanish?			English	Spanish

(5)				N/A
Full Donor name:				
DOB (MM/DD/YYYY):		Relationship to Patient:		
Address:				
City:		State:	Zip Code:	
Phone number:		Email:		
Should the related donor be given instructions in English or Spanish?			English	Spanish

(6)				N/A
Full Donor name:				
DOB (MM/DD/YYYY):		Relationship to Patient:		
Address:				
City:		State:	Zip Code:	
Phone number:		Email:		
Should the related donor be given instructions in English or Spanish?			English	Spanish

Return completed form to your NMDP case manager.

All testing will be completed by buccal swab.

Per PL-00107, *Policy for the Facilitation of Related Donor Requests*, NMDP is not able to facilitate related donor workup or subsequent donation requests for related donors under the age of 18.