The Clinical Directorate of Laboratory Medicine, Beaumont Hospital					
Doc No:	H&I-Form-509	**Revision**	2	**Active Date**	22.10.19

Histocompatibility Testing Request Form

Each Sample MUST be clearly labelled with FULL name, DOB & Date of collection. Failure to do may result in sample rejection. Samples cannot be processed without this form being completed in full.

Sample Requirements Store at Room Temp	**7.5ml EDTA**	**10ml Sodium Citrate**	**10ml Clotted**

Name (Please Print)		**Date of Birth**	
Centre		**Consultant**	
Hospital Number		**Gender**	
Patient Address		**Request Date**	
Address for Results			
Patient Category	**Kidney** ☐ **Pancrea** ☐ **Hea** ☐ **Lu** ☐ **Liver** ☐		
Sample Collection Date		**Blood Transfusion Dates**	
Patient Diagnosis		**Surgical History / Implants (Include Dates)**	
Number & Years of Pregnancies		**Previous Transplant(s) Date**	
Rituximab Treatment **IVIG Treatment** **Other (Please Specify)**	**Yes** ☐ **No** ☐ **Yes** ☐ **No** ☐	**Dialysis Type & Date Commenced (if applicable)**	

The Patient or designated individual MUST complete this section in order to consent to storage & testing of their samples. Please allow the patient time to read this section and answer any questions they may have with regard to the tests. The patient should tick the appropriate box to indicate their consent.

I consent to my samples being tested and stored for: HLA Typing Blood Group Typing [Tested in Beaumont Blood Transfusion Lab] HLA Antibody Screening Future clinical transplant related testing	Yes ☐	No ☐
I consent for my samples and information collected about me to be stored for possible future research (including DNA studies) related to kidney disease and transplantation. I understand that my identity will remain confidential at all times. I understand that I will not receive results of any research tests that may be performed, and that such research tests will not affect my treatment. I understand that agreeing that my sample can be used for future research is voluntary and that I am free to withdraw my consent at any time, without giving any reason and without my medical treatment being affected. Note: Any research being performed would be subject to approval by an independent body, which safeguards the welfare and rights of people in biomedical research studies – The Beaumont Hospital Ethics (Medical Research) committee.	Yes ☐	No ☐

Signature of Consenting Individual: _____

Relationship to patient if patient unable to sign: _____

Date Completed: _____

Consent Taken By: _____ **Position:**_____

Any queries may be directed via E-Mail to transplantlab@beaumont.ie or via Telephone at (01) 809 2651