|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| By completing this request form, you confirm the following:   1. you have complied with the requirements as set out in this form, the Anthony Nolan Testing Services terms and conditions and where appropriate, Anthony Nolan’s Histocompatibility Laboratories Service Provision User Guide; 2. you have obtained the appropriate patient or donor informed consent as applicable, and all other permissions required in accordance with all applicable law and regulation and guidelines or otherwise in order to permit the conduct of testing you have requested on the samples; and subject to acceptance by Anthony Nolan, you agree to be bound by the Anthony Nolan Testing Services terms and conditions available to view on our website at <https://www.anthonynolan.org/clinicians-and-researchers/transplant-and-laboratory-services/transplantation-services/guides-and-forms>, to the exclusion of all other terms and conditions (including any which you purport to apply subsequent to submission of this form). | | | | | | |
|  | | | | | | |
|  |  | |  | NHS Number |  |
| Transplant/ Requesting Centre |  | Contact details for whom the results are to be sent |  | | |
|  |  |  |  |
| **CORD DETAILS** | | | | | |
| Local Cord ID number |  | Cord registry |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Intended Transplant Date: |  | Cord - sex at birth |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **ASSOCIATED PATIENT DETAILS** | | |  | | | |  |
| First Name |  | | Surname | |  | DOB |  | |
|  |  | | | |  |
| Hospital/NHS Number |  | Sex at birth | |  | |

|  |  |
| --- | --- |
| Intended Transplant Date: |  |
|  |  | |  |

**IF URGENT PROCESSING IS REQUIRED, PLEASE EMAIL: clinicalservices@anthonynolan.org**

|  |  |  |  |
| --- | --- | --- | --- |
| **TEST REQUESTED** |  |  |  |

SAMPLE REQUIREMENT: according to EFI standards verification typing must be performed on a segment of the tubing integrally attached to the unit, if available, or otherwise, on a satellite vial, after shipment of the unit to the transplant centre. If neither a segment nor satellite vial is available, the verification typing must be performed on the content of the thawed unit, as soon after transplant as possible.

PLEASE CONFIRM WHICH OF THE FOLLOWING YOU ARE SENDING FOR VERIFICATION TYPING:

Segment of the tubing integrally attached to the unit 0 as well as date cord received at TC \_\_\_\_\_\_\_\_\_\_\_

OR

Satellite vial shipped with the unit 0 as well as date cord received at TC \_\_\_\_\_\_\_\_\_\_\_

OR

Unit bag, post infusion 0 as well as date cord thawed at TC \_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **PLEASE INDICATE WHETHER THIS IS A SINGLE OR DOUBLE CORD**: | Single | Double |

***Please refer to our*** [***privacy policy***](https://www.anthonynolan.org/privacy-policy)[***(www.anthonynolan.org/privacy-policy)***](https://www.anthonynolan.org/privacy-policy) ***for further information on how Anthony Nolan uses and stores personal information.***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **THIS SECTION MUST BE COMPLETED IN FULL** | | Name of Invoicee |  | **Purchase Order Number** |  |
|  | |  |  |  |  |
| Address of Invoicee |  | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **FOR LAB USE ONLY** |  |  |  |  |
| Patient / Donor Number |  | Sample number |  |
|  |  |  |  |
| Date / Time Received |  | Received By |  |