Leeds Cancer Centre

The Leeds Teaching Hospitals NHS Trust

HAEMATOLOGICAL MALIGNANCY DIAGNOSTIC SERVICE

Request for Chimerism Analysis Studies
(Sample to be provided urgently please to the address shown below)

Level 3 Bexley Wing, St. James's University Hospital, Beckett St. Leeds LS9 7TF
Tel: 0113 2067851 Email: hmds.lth@nhs.net

Please complete ALL sections:

Surname:	**Forename:**
NHS number:	**Patient number:**
Date of birth:	**Male / Female**
Referring hospital:	**Consultant:**

At least 3 points of Identification are required

Please label forms and sample(s) adequately

SAMPLE REQUIREMENTS
3 x 6ml EDTA
OR
2 x 10ml EDTA

Treatment

Non-Myeloablative Procedure ☐
(CD3 lineage restriction will be performed)

Select if CD15 lineage restriction is required ☐

Donor lymphocyte infusion (DLI) ☐

Conventional Allogenic Procedure ☐

Sample Timing (please tick appropriate box)

	Patient	Donor
Baseline	☐	☐
1 month post transplant	☐	N/A
3 months post transplant	☐	N/A
6 months post transplant	☐	N/A
12 months post transplant	☐	N/A
Other timepoint (please specify)	☐	N/A

For baseline samples, please provide Donor/ Recipient name

Date of transplant

Time Post DLI

Specimen taken by (FULL NAME REQUIRED IN ALL CASES):	**Contact details:**
Date/Time of sample:	