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 Donor lymphocyte infusion (DLI)

(CD3 lineage restriction will be performed)

Conventional Allogenic Procedure

Select if CD15 lineage restriction is required

**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:** |