COVER PAGE FOR HISTOCOMPATIBILITY REPORTS

- Please send this page with copies of the **original HLA typing reports** as provided by the HLA laboratory.
- Ensure that the **names** of the individuals **have been deleted** from the report before submitting it.
- If HLA typing reports are not sent simultaneously with the initial Med-AB, ensure that you have added **sufficient identifying data on this covering page** so that the patient/donor pair can be unambiguously identified.

Centre Identification

EBMT Code (CIC): ____________

Hospital: __________________________________ Unit: ____________________________________

Contact person: ____

E-mail: ____

Patient Identification

Has the HSCT been registered in the EBMT database? ☐ No ☐ Yes: UIC Number: ___________

Hospital Unique Patient Number/Code: __________________________

Initials: ____ – _____ (first name(s) – last name(s))

Date of birth: ______________________________
yyyy-mm-dd

Gender: ☐ Male ☐ Female

Date of HSCT: ______________________________
yyyy-mm-dd

Donor Identification

Donor ID: _______________________________

HLA typing results of patient and donor should be attached and sent to the DRST:

- Fax: 0731 1507 502
  or
- Email: support@drst.de