SUNY Downstate Transplant Laboratory
450 Clarkson Avenue Box 1197
Brooklyn, New York 11203
Room B2-303
Phone: 270-1914

REQUEST FOR POST TRANSPLANT ANTI-HLA ANTIBODY STUDIES**

(Prior authorization by Laboratory Director or Supervisor and a full red top tube are required for testing.)

Patient Name: _____

Date of Birth: _____

Date and Time Sample Drawn: _____

Name of Phlebotomist: _____

Donor Name: _____

Date of Transplant: _____

Test Requested By: _____

Contact Number: _____

Reason For Request: _____

_____

RESULTS: Single Antigen Class I_____ FLOW Anti-Tcell_____

Single Antigen Class II_____ FLOW Anti-Bcell_____

****All of the above information is required before sample is processed.**
Any further questions call Dr. Norin at 718-270-2516 or his cell at (917) 992-3967.