SUNY Downstate Transplant Laboratory
450 Clarkson Avenue Box 1197
Brooklyn, New York 11203
Room B2-303
Phone: (718) 270-1914

REQUEST FOR POST TRANSPLANT ANTI-HLA ANTIBODY STUDIES**

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

Patient Name: _____

Date of Birth: _____ MR# _____

Date and Time Sample Drawn: _____

Name of Phlebotomist: _____

Donor Name: _____

Date of Transplant: _____

Test Requested By: _____

Contact Number: _____

Reason For Request: _____

_____

RESULTS: Gen-Probe Screen CL 1 _____ Single Ag CL 1 _____

CL 2 _____ Single Ag CL 2 _____

**** All of the above information is required before sample is processed**
Questions: Contact the Transplant Lab at (718) 270-1914