

**IMPERIAL SIHMDS**

**CHIMERISM POST-TRANSPLANT request form**

Level 2 G-Block  
Hammersmith Hospital  
Du Cane Road  
London  
W12 0HS

**SPECIMEN RECEPTION HOURS :9am-5pm Monday-Friday**

**Molecular 020 3313 2179 [imperial.moleculardiagnosics@nhs.net](mailto:imperial.moleculardiagnosics@nhs.net)**

**Laboratory use only**

<p><b>PATIENT INFORMATION</b>                      NHS <input type="checkbox"/> PRIVATE <input type="checkbox"/></p> <p>SURNAME.....</p> <p>FORENAME.....</p> <p>DATE OF BIRTH ____/____/____ FEMALE <input type="checkbox"/> MALE <input type="checkbox"/></p> <p>Patient Address.....</p> <p>GP address/Dr.....</p> <p>HOSPITAL no.....</p> <p>NHS no.....</p>	<p><b>REFERRAL INFORMATION</b></p> <p>CONSULTANT/STR.....</p> <p>HOSPITAL.....</p> <p>MOBILE/BLEEP.....</p> <p>NHS.NET email.....</p> <p><b>INVOICING DETAILS (if different from referrer)</b></p> <p>PHONE/NHS.NET email.....</p>
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**DIAGNOSIS**.....

**ADDITIONAL CLINICAL INFORMATION (DLI, GvHD...)**.....

*Please fill in all the spaces and tick the appropriate boxes accurately. Failure to do so, might lead to the rejection of the sample.*

<p><b><u>SAMPLE INFORMATION</u></b></p> <p><b>BONE MARROW</b>                      <b>BLOOD</b></p> <p>SAMPLE DATE: ____/____/____ TIME ____:____</p>	<p><b><u>TRANSPLANT INFORMATION</u></b></p> <p>DATE OF TRANSPLANT: ____/____/____</p> <p>DAYS POST-TRANSPLANT _____</p> <p>TYPE OF TRANSPLANT: FULL <input type="checkbox"/>                      MINI <input type="checkbox"/></p> <p>DONOR GENDER: FEMALE <input type="checkbox"/>                      MALE <input type="checkbox"/></p>
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**CELL LINEAGE TO BE ASSESSED**

WHOLE BLOOD                       T-CELL

**FURTHER INFORMATION** \_\_\_\_\_

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