



HLA/Immunogenetics Laboratory
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FAX: (336) 774-7665

KIDNEY/PANCREAS TRANSPLANT CANDIDATE MONTHLY SERUM SCREEN REQUEST

Dialysis Center _____

Address _____

City, State _____

Telephone: _____

Attending Physician: _____

Patient Name	SSN# / Medicare#	Date Drawn	Sensitizing Event in past month? Yes or No

Please submit this form with the patient’s monthly sample. Serum must be received by the HLA Laboratory within seven calendar days of collection. Sera which exceed this time limit will be deemed unacceptable by the laboratory.

Please ship samples via FedEx to HLA/Immunogenetics Laboratory at address above.