

REQUEST FOR HLA TYPING

TESTING LABORATORY	SAMPLING
Customer n°: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> C / <input type="text"/>	Sampling date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Obligatory stamp	EDTA tube of whole blood (>5mL) Shipped refrigerated within 5 days maximum (room temperature tolerated)

PATIENT	PRESCRIBER
SURNAME	SURNAME
FIRST NAME	FIRST NAME
Maiden name	Address
Address	CP City
CP City	Tél. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date of birth: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Fax <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	E-mail address:

CONTEXT OF THE REQUEST	PRESCRIBED TEST
<input type="checkbox"/> Spondyloarthritis (and associated extra-articular manifestations) B27 (HLA class I: B*27)	<input type="checkbox"/> HLA-B27 screening by flow cytometry (OPL code: 90401) or genotyping if inconclusive test or if pre-analytical time >5 days
<input type="checkbox"/> Behçet's disease (and associated manifestations of aphthosis, uveitis) B51(5) (HLA class I: B*51)	<input type="checkbox"/> HLA Class I Locus B genotyping (B*27 allele only) (OPL code: GB27)
<input type="checkbox"/> Birdshot chorioretinopathy (and uveitis) A29 (HLA class I: A*29)	<input type="checkbox"/> HLA Class I Locus B genotyping (OPL code: BHLA1)
<input type="checkbox"/> Rheumatoid arthritis (chronic inflammatory rheumatism) DR1, DR4, DR10 and DR14 (HLA class II: DRB1*01,*04,*10 and *14)	<input type="checkbox"/> HLA Class I Locus A genotyping (OPL code: AHLA1)
<input type="checkbox"/> Narcolepsy (hypersomnia and attention disorders) DQ6 (HLA class II: DQB1*06:02)	<input type="checkbox"/> HLA Class II Locus DRB1 genotyping (OPL code: HLADR)
<input type="checkbox"/> Celiac disease (and gluten intolerance) DQ2 (HLA class II: DQA1*05:01/DQB1*02:01 and DQA1*05:05/DQB1*02:02) and DQ8 (HLA class II: DQA1*03/DQB1*03:02)	<input type="checkbox"/> HLA Class II Locus DQB1 genotyping (OPL code: HLADQ)
<input type="checkbox"/> Other (specify) :	<input type="checkbox"/> HLA Class II Locus DQB1 and Locus DQA1 genotyping (OPL code: HLDQA)
	<input type="checkbox"/> Other (specify) :

PHARMACOGENETICS	
<input type="checkbox"/> Screening before abacavir-based treatment (HLA B57)	<input type="checkbox"/> HLA-B*57:01 genotyping (OPL code: B5701)
<input type="checkbox"/> Screening before treatment with carbamazepine (HLA B15)	<input type="checkbox"/> HLA-B*15:02 and HLA-A*31:01 genotyping (OPL code: B1502)
<input type="checkbox"/> Hypersensitivity to allopurinol (HLA B58)	<input type="checkbox"/> HLA-B*58:01 genotyping (OPL code: B5801)

CONSULTATION CERTIFICATE FROM THE PRESCRIBING PHYSICIAN OR THE GENETIC COUNSELOR

I certify that I have informed the undersigned patient and his/her parents (legal representatives) about the characteristics of the investigated disease, how to diagnose it, how to prevent and treat it, how the disease is transmitted and the possible consequences in other members of the family, the storage of the sample, and that I have obtained the consent of the patient AND his/her guardianship under the conditions provided for by the French public health code (articles R113-4 and 5). The patient was informed in particular:

- The right to request at any time that this study be stopped, that the results not be communicated to me, or that the stored samples be destroyed,
- That the result of this examination will be reported and explained by the prescribing physician (or by delegation to the genetic counsellor) according to the current state of knowledge.

The patient authorizes:

The storage of a biosample taken to me and its subsequent use to continue investigations as part of the same diagnostic process, depending on the evolution of knowledge.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The transmission of a sample along with the necessary medical data, including any photographs, to another laboratory to complete this genetic study.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The recording and storage of medical data useful for the management of the diagnostic process in computer databases	<input type="checkbox"/> Yes <input type="checkbox"/> No
The Anonymised use of medical data and/or unused part of the samples within the framework of research projects without direct benefit or its use for internal laboratory quality assurance studies.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Done in on

PATIENT IDENTITY	IDENTITY OF THE LEGAL REPRESENTATIVE	PRESCRIBER
Last name: First name: Date of birth:	Last name: First name: Date of birth: Relationship to the patient :	Last name: First name:
<u>SIGNATURE</u>	<u>SIGNATURE</u>	<u>SIGNATURE</u>