Trillium Gift of Life Network
483 Bay Street South Tower, 4th Floor Toronto, Ontario M5G2C9

HLA Lab Requisition Form

TGLN Donor Number:		Sample Date:	
Date of Birth:		Age:	Sex: ☐ M ☐ F
Ethnicity:			
Cause of Death:			
Donor Hospital:			
Blood Type:	Subtype (if A or AB subtype required):		

Samples Sent

☐ Spleen ☐ Lymph Nodes ☐ Blood (ACD or EDTA) ☐ Cell Prep

Potential Recip. Type: ☐ Heart ☐ Lung ☐ K/P ☐ Kidney (s) ☐ Pancreas
☐ Composite Tissue ☐ Other: _____

Recipient Information

Recipient	TGLN Recip. Number	Transplant Hospital	Organ	ABO

Requested By:	
Date:	Time:
Call Results to (416) 214-7808	Pager Number: