Patient and Family Typing Request Form

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PATIENT INFORMATION – ☐ Patient Typing required

First Name:	Last Name:	
Address:		
City:	State:	Zip Code:
E-mail:		
Telephone:	Diagnosis:	
Date of Birth: / / (mm/dd/yyyy)		

Would you like to learn more about **raising awareness** and/or **growing the donor database**?
□ **YES**, I would like more information □ **NO**, I am not interested

RELATED DONOR INFORMATION – ☐ N/A if Patient Typing Only

First Name:	Last Name:	
Address:		
City:	State:	Zip Code:
E-mail:		
Telephone:	Fax:	
Date of Birth: / / (mm/dd/yyyy)	Relationship to Patient (please check one): ☐ Sibling ☐ Parent ☐ Child	

Would you like to join the unrelated donor registry and have the potential to be matched with patients other than your family member?
□ **YES**, I would like more information □ **NO**, I only want to be typed for my family member

Would you like to learn more about **raising awareness** and/or **growing the donor database**?
□ **YES**, I would like more information □ **NO**, I am not interested

TRANSPLANT CENTER

Transplant Center:		
City:	State:	Zip Code:
Physician's Name:		
Transplant Coordinator's Name:		
E-mail:	Telephone:	
HLA typing results to be sent to: ☐ Physician ☐ Transplant Coordinator		
Signature:	Date:	

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Responsibilities

DKMS Patient and Family Typing Program

1. **DKMS Responsibilities:** DKMS intends to (i) pay the costs associated with HLA typing of Transplant Center patients who are denied insurance coverage for such typing and who experience material delays in receiving insurance coverage for such typing and (ii) pay the costs associated with HLA typing of first degree (parents, children, and siblings) family members of Transplant Center patients who are denied insurance coverage for such family typing and who experience material delays in receiving insurance coverage for such family typing. DKMS' budget for free typing is limited. DKMS will inform requesting transplant centers if (a) request(s) cannot be fulfilled due to budgetary restrictions.

2. **Transplant Center Responsibilities: Requesting Transplant** Centers will be responsible for:

   a. Ensuring that the requisition form accompanying each cheek swab envelope represents the identity of the person who has swabbed, and that each cheek swab is securely and definitely mated to its requisition form at shipment;
   b. Obtaining the patient's and/or family member's informed consent;
   c. If a family member is typed, determining if the family member is an appropriate match for the patient;
   d. If a family member is typed, ensuring that the family member has accurate and comprehensive information regarding the donation process;
   e. Performing confirmatory typing on the patient and/or family member prior to transplant.

   DKMS is solely providing costs associated with HLA typing and, therefore, is not responsible for any decisions regarding the treatment or matching of patients.

3. **Confidentiality:** Except as may be required by any applicable law, government order, or regulation, or by order or decree of any court of competent jurisdiction, no Party shall, without prior written consent of the other, publicly divulge, announce or in any manner disclose to any unrelated third party, any confidential or proprietary information revealed to it by the other Party pursuant hereto, or any of the specific terms and conditions stipulated herein, and each Party shall do all such things as are reasonably necessary to prevent any such information from becoming known to any person other than the Parties to this pursuant hereto.