



**HISTOCOMPATIBILITY LAB
TRANSPLANT TESTING**
Phone 800-245-3117 x 6201
Fax (414) 937-6322

Person Completing Requisition		
Institution	Client#	
Dept	Physician	
Address		
City	ST	ZIP
Phone (Lab)	Phone (Physician)	

Patient/Sample Name

Last		First		MI	
MR #	Accession #		SS #	-	-
DOB / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Ethnicity	<input type="checkbox"/> Caucasian	<input type="checkbox"/> African American	<input type="checkbox"/> Hispanic <input type="checkbox"/> Asian
			<input type="checkbox"/> Ashkenazi Jewish	<input type="checkbox"/> Other	
Specimen Type	<input type="checkbox"/> Blood <input type="checkbox"/> Buccal Swabs <input type="checkbox"/> Plasma <input type="checkbox"/> Serum <input type="checkbox"/> DNA			Draw Date	/ /
				<input type="checkbox"/> Umbilical Cord Blood	<input type="checkbox"/> Other
Anticoagulant	<input type="checkbox"/> EDTA <input type="checkbox"/> ACDA <input type="checkbox"/> ACDB <input type="checkbox"/> Sodium Heparin <input type="checkbox"/> Clot			Draw Time	
				<input type="checkbox"/> Other	

Indicate Special Requests

Reporting: _____
PO# _____

Is testing for outpatient Medicare enrollee or Wisconsin Medicaid recipient? Yes No If yes, please complete information on reverse.

PATIENT HISTORY

Transfusion History Unknown None Multiple _____ Last Transfusion _____ / _____ / _____ of: _____
Diagnosis: _____ Number Previous Typing, if known: _____
HLA-A _____ HLA-B _____ HLA-C _____ HLA-DR _____ HLA-DQ _____ HLA-DP _____

TRANSPLANT WORKUP

Initial Workup

Type: Bone Marrow (Stem Cell) Kidney Pancreas Liver Heart Lung Deceased Organ Donor
 Other _____

REQUIRED FOR TRANSPLANT RECIPIENTS

Coordinator Name: _____ Phone # _____
Previous Transplant? No Yes Type: _____ Date: _____ / _____ / _____ Transplant Center: _____
Number of pregnancies (including miscarriages and abortions): _____
Sample is from: Recipient Prospective Donor Name of Recipient: _____
Relationship to Recipient: _____ Recipient's Transplant Center: _____

TRANSPLANT TESTING

- | | |
|--|---|
| <input type="checkbox"/> ABO/Rh (2200) | <input type="checkbox"/> HLA-C Intermediate Resolution (2506) |
| <input type="checkbox"/> Autocrossmatch (Flow Cytometric Crossmatch) (2600) | <input type="checkbox"/> HLA-AB Intermediate Resolution (2520) |
| <input type="checkbox"/> Crossmatch (Flow Cytometric Crossmatch with recipient) (2610) | <input type="checkbox"/> HLA-ABC Intermediate Resolution (2347) |
| <input type="checkbox"/> Crossmatch Titration (Flow Cytometry) (2601) | <input type="checkbox"/> HLA-A,B,DRB1 Intermediate Resolution (2522) |
| <input type="checkbox"/> HLA Antibody Detection (Flow Cytometry) (2235) | <input type="checkbox"/> HLA-DRB1 Intermediate Resolution (2507) |
| <input type="checkbox"/> HLA Antibody Identification Class I High Resolution (2226) | <input type="checkbox"/> HLA-DRB3,B4,B5 Intermediate Resolution (2321) |
| <input type="checkbox"/> HLA Antibody Identification Class II High Resolution (2231) | <input type="checkbox"/> HLA-DQB1/-DQA1 Intermediate Resolution (2508) |
| <input type="checkbox"/> HLA-A Low Resolution (2304) | <input type="checkbox"/> HLA-DPB1 Intermediate Resolution (2513) |
| <input type="checkbox"/> HLA-B Low Resolution (2305) | <input type="checkbox"/> HLA-B/DRB1 Intermediate Resolution (Verification Typing)(2319) |
| <input type="checkbox"/> HLA-C Low Resolution (2306) | <input type="checkbox"/> HLA-A High Resolution (2324) |
| <input type="checkbox"/> HLA-AB Low Resolution (2303) | <input type="checkbox"/> HLA-B High Resolution (2325) |
| <input type="checkbox"/> HLA-ABC Low Resolution (2302) | <input type="checkbox"/> HLA-C High Resolution (2326) |
| <input type="checkbox"/> HLA-DRB1 Low Resolution (2307) | <input type="checkbox"/> HLA-ABC High Resolution (2329) |
| <input type="checkbox"/> HLA-DRB3,B4,B5 Low Resolution (2122) | <input type="checkbox"/> HLA-DRB1 High Resolution (2322) |
| <input type="checkbox"/> HLA-DRB1 and -DQB1/-DQA1 Low Resolution (2553) | <input type="checkbox"/> HLA-DQB1 High Resolution (2328) |
| <input type="checkbox"/> HLA-DQB1/-DQA1 Low Resolution (2308) | <input type="checkbox"/> HLA-DPB1 High Resolution (2323) |
| <input type="checkbox"/> HLA-DPB1 Low Resolution (2313) | <input type="checkbox"/> HLA High Resolution Panel by NGS (2300) |
| <input type="checkbox"/> HLA-A Intermediate Resolution (2504) | <input type="checkbox"/> HLA Haplotype by STR (2380) |
| <input type="checkbox"/> HLA-B Intermediate Resolution (2505) | <input type="checkbox"/> KIR Genotyping (2377) |

STAT Testing
Results Required No Later Than
Date: _____
Time: _____

BCW Use Only

_____ HEPB	_____ ACDA	Opened By _____
_____ Clot	_____ ACDB	Evaluated By _____
_____ Other _____	_____ EDTA	Reviewed By _____
		Labeled By _____

BloodCenter of Wisconsin does NOT bill patients or their insurance. Call 800-245-3117 ext. 6250 for your Client#.

DRAWING INSTRUCTIONS: Tubes must be individually labeled with **FULL NAME OF INDIVIDUAL, ANOTHER IDENTIFIER (e.g., SSN, MRN, DOB), DATE AND TIME OF DRAWING.** Samples cannot be accepted after any exposure to an environment in which HLA genes are amplified. This precaution is essential to avoid contamination of samples with DNA that could alter test results. **Samples will be accepted from 8:00 a.m. Monday through noon on Friday.** Emergency testing **MUST** be arranged through the laboratory. Call (414) 937-6201.

TEST	SAMPLE REQUIREMENTS	SHIP
HLA Antibody Detection & Identification, Kidney recipient monthly HLA antibody	10-ml Clotted (red top) blood (pre-dialysis for kidney recipient HLA antibody testing)	Room temperature
Kidney, Heart, Liver, Pancreas, Lung Recipient - Initial Workup	20-ml Clotted (red top) blood and 14 ml EDTA (lavender top) blood. Must be drawn pre-dialysis	Room temperature
Kidney Donor Workup	40-ml Sodium Heparinized whole blood (green top)* and 20-ml Clotted (red top) blood and 14 ml EDTA (lavender top) blood. If crossmatches are to be performed, a 10-ml Clotted (red top) sample from recipient is required.	Room temperature
Flow Cytometry Crossmatch	40-ml Sodium Heparinized whole blood (green top) and 10 ml Clotted (red top). If crossmatches are to be performed, a 10-ml Clotted (red top) sample from recipient is required.	Room temperature
Crossmatch Titration (flow cytometry)	60-ml Sodium Heparinized whole blood (green top) and 10 ml Clotted (red top). If crossmatches are to be performed, a 10-ml Clotted (red top) sample from recipient is required.	Room temperature
HLA Low or Intermediate or High Resolution (A, B, C, AB, ABC, DRB1, DRB3,B4,B5, DQB1, DQB1/DQA1, DPB1)	14-ml EDTA (lavender top) whole blood or 4 buccal swabs (contact laboratory if submitting cord blood)	Room temperature
HLA Haplotype by STR or KIR Genotyping	5-ml EDTA (lavender top) whole blood or 4 buccal swabs (contact laboratory if submitting cord blood or purified DNA)	Room Temperature

If samples submitted for crossmatching (sodium heparin tubes) will not be received by our lab within 24 hours, use ACD **solution B** to replace sodium heparinized whole blood.

Contact laboratory for pediatric drawing requirements or low white cell count drawing requirements. Blood samples should be shipped by overnight carrier. The package must be shipped in compliance with carrier's guidelines. Please contact your carrier for current biohazardous shipping regulations.

Packages should be addressed to:

**Client Services/Histocompatibility Laboratory
BLOODCENTER OF WISCONSIN
638 North 18th Street
Milwaukee, WI 53233**

Label box:

Refrigerate, Room Temperature, or Frozen -- whichever is appropriate.

MEDICARE (OUTPATIENT) AND MEDICAID BILLING INFORMATION

BloodCenter of Wisconsin will bill the institution directly unless testing is performed on an OUTPATIENT Medicare enrollee or a Medicaid recipient from WI.

Medicare #	_____
Railroad Retiree #	_____
Medicaid #	_____ (Wisconsin only)
Patient's Address	_____ _____
City	_____ State _____ Zip _____
Diagnosis	_____ Diagnosis Code _____
Referring Physician's Full Name	_____
Referring Physician's Provider # (UPIN #)	_____ Physician's Phone Number _____