Reset Form

HEALTH
UNIVERSITY OF UTAH

HISTOCOMPATIBILITY TESTING REQUISITION

Registration card imprint or patient demographics

Histocompatibility & Immunogenetics Laboratory CLIA# 46D0679773
417 Wakara Way, Suite 3220
Salt Lake City, UT 84108
Phone (801) 581-3116 / Fax (801) 585-3670
Visit us on the web: https://healthcare.utah.edu/histocompatibility-immunogenetics-lab/

Requester Information (please complete in full):

Today's Date:	Your Name:	Your Location: *(i.e. dept. name)*
Your Phone#:	Send results to: *(fax or e-mail)*	SAMPLE DATE: *(must match date on sample tube(s))*

Patient: Demographics (complete in full) Federal regulations (CLIA '88) require this entire section to be completed in full. All clinical blood specimens (tubes, containers) must be labeled with full name of the individual, individual's DOB, sample date, and phlebotomist's initials. If labeling is incomplete, the lab must delay or refuse testing. We accept samples from 7:00am Monday - 11:00am Friday.

Person Tested: *(last, first, middle initial)*			MRN:		SSN:
DOB:	Sex:	Race:	Hospital *(invoiced)*		Physician:
Recipient Diagnosis/Disease: *(ICD-9 or written descrip.)*			Recipient Name: *(if person tested is donor)*	Recip. Identifier:	Relation to recipient:

Transplant Type (mark appropriate): ☐ autoBMT ☐ alloBMT ☐ Kidney ☐ Pancreas ☐ Heart ☐ Liver ☐ Lung ☐ Other: _____

Testing Requirements (All tests require a physician's order): **Do not refrigerate any sample**

	HLA TYPING	Specimen Requirements
☐	Solid organ transplant- Recipient OR Donor (includes virtual crossmatch)	2x 5mL EDTA **OR** Pediatric 2x2mL
☐	Hematopoietic stem cell ALLO RECIPIENT◆ Routine ☐ STAT ☐	2x 5mL EDTA **OR** Pediatric 2x2mL
☐	Hematopoietic stem cell AUTO RECIPIENT OR Platelet refractory pt.	2x 5mL EDTA **OR** Pediatric 2x2mL
☐	Hematopoietic stem cell DONOR◆ Routine ☐ STAT ☐	2x 5mL EDTA **OR** Pediatric 2x2mL
☐	Confirmatory HLA typing	2x 5mL EDTA **OR** Pediatric 2x2mL
☐	Disease association- Specify Locus OR Antigen/s: _____	2x 5mL EDTA **OR** Pediatric 2x2mL
	HLA ANTIBODY TESTING (Pre/Post Transplant)	**Specimen Requirements**
☐	**PRE**-Transplant Standard HLA Antibody Identification◆ *STAT ☐ Routine ☐ Quarterly ☐ Store only ☐	1x 7mL red top within72 hours **OR** Pediatric 2mL
☐	**POST**-Transplant Testing for donor specific antibodies (DSA) Reason?: *STAT ☐ Routine ☐ other _____	1x 7mL red top within72 hours **OR** Pediatric 2mL
☐	Hematopoietic Stem Cell **PRE**-Transplant Testing for DSA Donor ID _____	1x 7mL red top within72 hours **OR** Pediatric 2mL
	CROSSMATCHING	**Specimen Requirements**
☐	RECIPIENT- Lymphocyte Crossmatch O.R. date: _____ Donor ID: _____	7mL whole blood in red top tube from recipient within 72 hours **OR** 2mL for pediatric
☐	DONOR- Lymphocyte Crossmatch	3x 10mL whole blood in yellow top (ACD) tubes within 48 hours
	MISCELLANEOUS	**Specimen Requirements** *(call lab for pediatric draw volumes)*
☐	Special Studies (please specify): _____	Contact lab for specimen requirements at 801-581-3116

◆Client should be advised that based upon initial results, additional testing may be necessary along with additional charges.

***STAT samples received by 9am will be reported the same day**

modified 4/16/19