UNIVERSITY of MARYLAND MEDICAL CENTER

Laboratories of Pathology - Immunogenetics Laboratory
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Requisition for HLA Typing and Histocompatibility Testing / Stem Cell Transplant Program

DONOR NAME: **MRN# / SSN#:** **DOB:** **Gender: ☐ Male / ☐ Female / ☐ Unknown**	**PATIENT NAME:** **MRN# / SSN#:** **DOB:** **Gender: ☐ Male / ☐ Female / ☐ Unknown**
Donor Diagnosis Code: V59.02 **Donor Relationship to Patient**:	**Patient Diagnosis Code:**
Specimen Information: Specimen Collection Date: _____/_____/_____ Time: _____ Specimen Type: ☐ Whole Blood ☐ Serum (Clot) ☐ Buccal Swab ☐ Bone Marrow ☐ Other _____ ☐ USE STORED SAMPLE FOR TESTING ☐ This is a second independently tested sample for HLA typing verification / confirmation of the: _____ Donor _____ Recipient	**Specimen Transport and Labeling Requirements:** Store all samples at Room Temperature Specimens for Flow Crossmatching must be received immediately and performed within 48 hours. All requisitions MUST be clearly signed with a contact phone or beeper number, and dated **Testing Priority:** Routine priority will apply. Contact the laboratory if expedited typing is required.

HLA Typing

Test(s)	**Specimen Requirements**	**Test Code (For Lab Use Only)**
☐ **HLA Typing - High Resolution Sequencing**	7 ml ACD (Yellow Top) Whole Blood or other nucleated cell source	NGS (B)
HLA Antibody Analysis and Crossmatch		
☐ **HLA Class I and Class II Antibody Analysis**	10 ml Clotted (Red Top) Blood from Recipient	Ab Analysis (B)
☐ **Flow Cytometric Crossmatch**	One 10 ml Clotted (Red Top) Blood from Recipient ***and*** Four 7 ml ACD (Yellow Top) Blood from Donor	FCM (B)
☐ **Virtual Crossmatch**	Patient and Donor must be typed for all HLA Loci, and should be typed at the allele level by sequencing	VXM
Platelet Transfusion Support ONLY (TAT 1 PRIORITY)		
☐ **HLA Class I Antibody Analysis**	10 ml Clotted (Red Top) Blood from Recipient	HD PRA 1
☐ **HLA Class I C1q Binding Assay**	Must be on same sample as HLA Antibody Analysis	C1Q PRA 1

Has the patient received monoclonal antibody therapy within the last year (e.g. ATG; Rituximab; IVIg, etc)? Yes____ No____ Unknown_____

SPECIAL INSTRUCTIONS: _____

THE FOLLOWING INFORMATION IS required if verbal notification regarding Unacceptable Specimens is desired:

1 – Requesting / Attending Physician or LIP:_____**Date:**_____

2 - Charge Nurse Contact Information for Specimen Issues: _____**Phone:**_____