

Transplant Immunology Laboratory Methodist Hospital 1701 N. Senate Blvd, Indianapolis, IN 46202 Telephone 317-962-6196, FAX 317-962-6195 CLIA# 15D0662523

TRANSPLANT IMMUNOLOGY REQUISITION

(RETURN THIS FORM WITH BLOOD SAMPLE)

Name	of person being drawn:	
MRN.		Date of Birth:
ICD-9 Test request:		Coordinator
	HLA Initial RENAL and/or PANCREAS evaluation (2 red, 3 ACD) Please provide the following information for any evaluation for KI, PA, MVT &/or LI: # Pregnancies: # Transfusions: Prev Txp	
	HLA Initial Liver evaluation (2 red, 1 ACD)	
	HLA Initial Multivisceral evaluation (also for liver/kidney, liver/pancreas) (2 red, 3 ACD)	
	HLA Monthly PRA (1 red)	
	HLA Potential Living donor evaluation (1 red, 3 ACD)	
	Recipient name	
	Recipient MRN	
	Donor relationship to recipient	
	Final Crossmatch, Living Donor: Recipient: HLA Final Renal and/or Pancreas Crossmatch Recipient Donor: HLA Crossmatch Living Donor	
	Intermediate Crossmatch, Living Do Recipient: HLA Intermediate R Donor: HLA Crossmatch Livin	enal and/or Pancreas Crossmatch Recipient
Authorized Signature:		Date

SEND TO METHODIST HLA LAB VIA IU SPECIMEN RECEIVING. TUBE TO 260

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When ordering tests for Medicare or Medicaid patients, please select only those tests that are medically necessary for the diagnosis or treatment of the patient. Medicare does not pay for routine screening tests,