Histocompatibility Lab | Transplant Testing

Phone: 800-245-3117 x6250 | Fax 414-937-6322

NOTE: Versiti does NOT bill patients or insurance. Test orders must be placed through a medical facility that has an account with Versiti. Client # required.

Ordering Institution Information

Person Completing Requisition:	Physician/Provider:		
Institution:	Dept:		Client #:
Address:	City:	State:	Zip Code:
Phone (Lab):	Provider Contact (phone/email):		
Special Reporting Requests:			PO #:

Is testing for outpatient Medicare enrollee or Wisconsin Medicaid recipient? ☐ Yes ☐ No
If yes, please complete the beneficiary form located at https://versiti.org/products-services/requisitions and submit with this requisition.

Patient Information

Last Name:	First Name:	MI:	DOB:
MR#:	Accession #:		

Biologic Sex/Sex Assigned at Birth: ☐ Male ☐ Female ☐Other

Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Ashkenazi Jewish ☐ Other ____________________

Specimen Information

Specimen Type: ☐ Blood ☐ Buccal Swabs ☐ Plasma ☐ Serum ☐ DNA ☐ Umbilical Cord Blood ☐ Other ______________________________

Anticoagulant: ☐ EDTA ☐ ACDA ☐ ACDB ☐ Clot ☐ Sodium Heparin ☐Other ________ | Draw Date: | Draw Time:

Patient History

Transfusion History: ☐ Unknown ☐ None ☐ Multiple ________ *(number)* | Last Transfusion: _____/_____/_____ of: _________________

Diagnosis:

☐ Previous Typing *(If Available, Attach Typing Results)* | HLA-A _____ HLA-B _____ HLA-C _____ HLA-DR _____ HLA-DQ _____ HLA-DP _____

Required For Transplant Workup

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

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

- ☐ ABO/Rh (2200)
- ☐ Auto-crossmatch (Flow Cytometric Crossmatch) (2600)
- ☐ Allo-crossmatch (Flow Cytometric Crossmatch with Recipient) (2610)
- ☐ Allo-crossmatch Titration (Flow Cytometry) (2601)
- ☐ HLA Antibody Detection (Flow Cytometry) (2235)
- ☐ HLA Antibody Identification Class I High Resolution (2226)
- ☐ HLA Antibody Identification Class II High Resolution (2231)
- ☐ HLA Antibody Identification Class I Dilution - High Resolution (2225)
- ☐ HLA Antibody Identification Class II Dilution - High Resolution (2230)
- ☐ HLA-A Low Resolution (2304)
- ☐ HLA-B Low Resolution (2305)
- ☐ HLA-C Low Resolution (2306)
- ☐ HLA-AB Low Resolution (2303)
- ☐ HLA-ABC Low Resolution (2302)
- ☐ HLA-DRB1 Low Resolution (2307)
- ☐ HLA-DRB3, B4, B5 Low Resolution (2122)
- ☐ HLA-DRB1 and -DQB1/-DQA1 Low Resolution (2553)
- ☐ HLA-DQB1/-DQA1 Low Resolution (2308)
- ☐ HLA-DPB1/-DPA1 Low Resolution (2318)
- ☐ HLA-A Intermediate Resolution (2504)
- ☐ HLA-B Intermediate Resolution (2505)
- ☐ HLA-C Intermediate Resolution (2506)
- ☐ HLA-AB Intermediate Resolution (2520)
- ☐ HLA-ABC Intermediate Resolution (2347)
- ☐ HLA-A, B, DRB1 Intermediate Resolution (2522)
- ☐ HLA-DRB1 Intermediate Resolution (2507)
- ☐ HLA-DRB3, B4, B5 Intermediate Resolution (2321)
- ☐ HLA-DQB1/-DQA1 Intermediate Resolution (2508)
- ☐ HLA-DPB1/-DPA1 Intermediate Resolution (2513)
- ☐ HLA-B/DRB1 Intermediate Resolution (Verification Typing) (2319)
- ☐ HLA-A High Resolution (2324)
- ☐ HLA-B High Resolution (2325)
- ☐ HLA-C High Resolution (2326)
- ☐ HLA-ABC High Resolution (2329)
- ☐ HLA-DRB1 High Resolution (2322)
- ☐ HLA-DQB1 High Resolution (2328)
- ☐ HLA-DPB1 High Resolution (2323)
- ☐ HLA High Resolution Panel by NGS (2300)
- ☐ HLA Haplotype by STR (2380)
- ☐ KIR Genotyping (2377)

STAT Testing	VERSITI USE ONLY	
☐ **STAT Testing (STAT Fee Applies)**	____ HEPB ____ ACDA ____ ACDB ____ EDTA	
Results Required No Later Than: Date Needed By: _____/_____/_____ Time: _____:______	____ Clot ____Other: _________________	
Contact Name:	Opened By:	Reviewed By:
Contact Phone #:	Evaluated By:	Labeled By:

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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	STORE & SHIP
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
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
Flow Cytometry Crossmatch*	40-ml ACD solution B (yellow 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 ACD solution B (yellow 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
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 ACD solution B (yellow 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

*Sodium Heparin whole blood is acceptable if received within 24 hours of draw.

SHIPPING INFORMATION

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

Label Box: Refrigerate, Room Temperature, or Frozen (whichever is appropriate)

Packages should be addressed to:

Versiti Wisconsin – Histocompatibility Laboratory
638 N 18th Street
Milwaukee, WI 53233