

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

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



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

Patient/Sample Name		Last			First			MI		
MR #				Accession #				SSN	-	-
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 <input type="checkbox"/> Umbilical Cord Blood <input type="checkbox"/> Other _____					Draw Date	/	/		
Anticoagulant	<input type="checkbox"/> EDTA <input type="checkbox"/> ACDA <input type="checkbox"/> ACDB <input type="checkbox"/> Clot <input type="checkbox"/> Other _____					Draw Time				
Special Reporting Requests:								PO#:		

Medicare

Is testing for outpatient Medicare enrollee or Wisconsin Medicaid recipient? Yes No

If yes, please complete our beneficiary form located at www.versiti.org/medical-professionals/products-services/requisitions and submit with this requisition

PATIENT HISTORY

Potential Platelet Recipient? Yes No If yes, please complete information below:

****Determine if STAT Testing is required and alert Histocompatibility Lab if STAT Testing is required (refer to bottom left section and drawing instructions on back/next page).**

Transfusion History Unknown None Multiple _____ Last Transfusion _____ / _____ / _____ of: _____
Number

Diagnosis: _____ Previous Typing, if known: _____

HLA-A _____ HLA-B _____ HLA-C _____ HLA-DR _____ HLA-DQ _____ HLA-DP _____

HLA MATCHED PLATELET TRANSFUSION WORKUP

<input type="checkbox"/> HLA-AB Low Resolution (2303)	<input type="checkbox"/> STAT Testing (STAT Fee Applies) – complete bottom left section
<input type="checkbox"/> HLA Antibody Identification Class I High Resolution (2226)	

HLA TYPING

<input type="checkbox"/> HLA-A Low Resolution (2304)	<input type="checkbox"/> HLA-A High Resolution by DNA Sequencing (2324)
<input type="checkbox"/> HLA-B Low Resolution (2305)	<input type="checkbox"/> HLA-B High Resolution by DNA Sequencing (2325)
<input type="checkbox"/> HLA-C Low Resolution (2306)	<input type="checkbox"/> HLA-C High Resolution by DNA Sequencing (2326)
<input type="checkbox"/> HLA-ABC Low Resolution (2302)	<input type="checkbox"/> HLA-ABC High Resolution (2329)
<input type="checkbox"/> HLA-DRB1 Low Resolution (2307)	<input type="checkbox"/> HLA-DRB1 High Resolution by DNA Sequencing (2322)
<input type="checkbox"/> HLA-DRB3, B4, B5 Low Resolution (2122)	<input type="checkbox"/> HLA-DRB3*01 (DR52) Determination (5252)
<input type="checkbox"/> HLA-DRB1 and -DQA1/-DQB1 Low Resolution (2553)	<input type="checkbox"/> HLA-DQB1 High Resolution by DNA Sequencing (2328)
<input type="checkbox"/> HLA-DQA1/-DQB1 Low Resolution (2308)	<input type="checkbox"/> HLA-DPB1 High Resolution by DNA Sequencing (2323)
<input type="checkbox"/> HLA-DPB1 Low Resolution (2313)	

HLA DISEASE ASSOCIATION TESTING

<input type="checkbox"/> HLA-A*02:01 Determination (2279)	<input type="checkbox"/> HLA-B*15:02 Determination (2276)
<input type="checkbox"/> HLA-A29 Determination (2274)	<input type="checkbox"/> HLA-B*57:01 Determination (2272)
<input type="checkbox"/> HLA-B27 Determination (2271)	<input type="checkbox"/> HLA-DR Single Antigen (2361) Specify: _____
<input type="checkbox"/> HLA-B51 Determination (2275)	<input type="checkbox"/> HLA Typing for Narcolepsy (2270)

HLA ANTIBODY TESTING

<input type="checkbox"/> HLA Antibody Detection (Flow Cytometry) (2235) (If positive, will reflex to HLA Antibody ID Class I / II)	<input type="checkbox"/> HLA Antibody Identification Class I High Resolution (2226)
	<input type="checkbox"/> HLA Antibody Identification Class II High Resolution (2231)

STAT Testing - STAT Fee Applies
Results Required No Later Than

Date Needed By: (_____ / _____ / _____) Time: _____ : _____
M M D D Y Y

Contact Phone #: _____

Contact Name: _____

Versiti Use Only		
_____ HEPB	_____ ACDA	Opened By _____
_____ Clot	_____ ACDB	Evaluated By _____
_____ Other _____	_____ EDTA	Reviewed 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 and SHIP
HLA Low Resolution (A, B, C, AB, ABC, DRB1, DRB3B4B5, DQB1/DQA1, DPB1), HLA-A29, HLA-B27, HLA-B51, HLA-Narcolepsy, HLA-DR Single Antigen	5 - 14 ml EDTA whole blood (lavender top) or ACDA whole blood (yellow top) or 4 buccal swabs	Room temperature
HLA High Resolution (A, B, C, DRB1, DQB1, DPB1), HLA-A*02:01, HLA-B*15:02, HLA-B*57:01	5 - 14 ml EDTA whole blood (lavender top) or ACDA whole blood (yellow top) or 4 buccal swabs	Room temperature
HLA Antibody Detection, HLA Antibody Identification	10 ml Clotted (red top) blood	Room temperature
Platelet Recipient: - HLA-AB Low Resolution - HLA Antibody Identification Class I High Resolution * Indicate STAT Testing, if required	14 ml EDTA whole blood (lavender top) or 4 buccal swabs and 10 ml Clotted (red top) blood	Room temperature
Kidney, Heart, Liver, Pancreas, Lung Recipient - Initial Workup	REFER to HISTOCOMPATIBILITY LAB TRANSPLANT TESTING REQUISITION	Room temperature
Kidney Donor Workup	REFER to HISTOCOMPATIBILITY LAB TRANSPLANT TESTING REQUISITION	Room temperature
Crossmatch (Flow Cytometric)	REFER to HISTOCOMPATIBILITY LAB TRANSPLANT TESTING REQUISITION	Room temperature
Bone Marrow (Stem Cell) recipients or donors	REFER to HISTOCOMPATIBILITY LAB TRANSPLANT TESTING REQUISITION	Room temperature

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:

Versiti Wisconsin - Histocompatibility Laboratory
638 North 18th Street
Milwaukee, WI 53233

Label box:

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