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
TRANSPLANT TESTING
Phone 800-245-3117 x 6201
Fax (414) 937-6322

Patient/Sample Name	Last		First		MI		
MR #		Accession #		**SSN**	- -		
DOB	/ /	Gender	☐ M ☐ F	Ethnicity	☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Ashkenazi Jewish ☐ Other		
Specimen Type	☐ Blood ☐ Buccal Swabs ☐ Plasma ☐ Serum ☐ DNA ☐ Umbilical Cord Blood ☐ Other _____				Draw Date	/ /	
Anticoagulant	☐ EDTA ☐ ACDA ☐ ACDB ☐ Clot ☐ Sodium Heparin ☐ 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

Transfusion History ☐ Unknown ☐ None ☐ Multiple_____Last Transfusion_____/_____/_____of: _____

Diagnosis:_____Number Previous Typing, if known: _____

HLA-A_____HLA-B_____HLA-C_____HLA-DR_____HLA-DQ_____HLA-DP_____

TRANSPLANT WORKUP ☐ Initial Workup

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

☐ Other _____

REQUIRED FOR TRANSPLANT RECIPIENTS

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)
☐ Autocrossmatch (Flow Cytometric Crossmatch) (2600)
☐ Crossmatch (Flow Cytometric Crossmatch with recipient) (2610)
☐ 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-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 Low Resolution (2313)
☐ 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 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**

Results Required No Later Than - Date:_____Time:_____

Rev Date 08/31/19 CLIA # 52D1009037 Medicare Provider # 84481

Versiti Use Only

____ HEPB	____ ACDA	Opened By	_____
____ Clot	____ ACDB	Evaluated By	_____
	____ EDTA	Reviewed By	_____
____ Other _____		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 Antibody Detection & Identification, Kidney recipient monthly HLA antibody	10-ml Clotted (red top) blood (pre-dialysis for kidney recipient HLA antibody testing)	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 Sodium Heparinized whole blood (green 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
Flow Cytometry Crossmatch*****	40-ml Sodium Heparinized whole blood (green 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 Sodium Heparinized whole blood (green 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
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

*If samples submitted for crossmatching (sodium heparin tubes) will not be received by our lab within 24 hours, use ACD **solution B** to replace sodium heparinized whole blood.

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.