

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	<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"/> Sodium Heparin <input type="checkbox"/> Other _____					Draw Time		

Special Reporting Requests:	PO#:
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Medicare

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

If yes, please complete our [beneficiary form](http://www.versiti.org/medical-professionals/products-services/requisitions) 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

- | | |
|--|--|
| <input type="checkbox"/> ABO/Rh (2200)
<input type="checkbox"/> Autocrossmatch (Flow Cytometric Crossmatch) (2600)
<input type="checkbox"/> Crossmatch (Flow Cytometric Crossmatch with recipient) (2610)
<input type="checkbox"/> Crossmatch Titration (Flow Cytometry) (2601)
<input type="checkbox"/> HLA Antibody Detection (Flow Cytometry) (2235)
<input type="checkbox"/> HLA Antibody Identification Class I High Resolution (2226)
<input type="checkbox"/> HLA Antibody Identification Class II High Resolution (2231)
<input type="checkbox"/> HLA-A Low Resolution (2304)
<input type="checkbox"/> HLA-B Low Resolution (2305)
<input type="checkbox"/> HLA-C Low Resolution (2306)
<input type="checkbox"/> HLA-AB Low Resolution (2303)
<input type="checkbox"/> HLA-ABC Low Resolution (2302)
<input type="checkbox"/> HLA-DRB1 Low Resolution (2307)
<input type="checkbox"/> HLA-DRB3,B4,B5 Low Resolution (2122)
<input type="checkbox"/> HLA-DRB1 and -DQB1/-DQA1 Low Resolution (2553)
<input type="checkbox"/> HLA-DQB1/-DQA1 Low Resolution (2308)
<input type="checkbox"/> HLA-DPB1 Low Resolution (2313)
<input type="checkbox"/> HLA-A Intermediate Resolution (2504)
<input type="checkbox"/> HLA-B Intermediate Resolution (2505) | <input type="checkbox"/> HLA-C Intermediate Resolution (2506)
<input type="checkbox"/> HLA-AB Intermediate Resolution (2520)
<input type="checkbox"/> HLA-ABC Intermediate Resolution (2347)
<input type="checkbox"/> HLA-A,B,DRB1 Intermediate Resolution (2522)
<input type="checkbox"/> HLA-DRB1 Intermediate Resolution (2507)
<input type="checkbox"/> HLA-DRB3,B4,B5 Intermediate Resolution (2321)
<input type="checkbox"/> HLA-DQB1/-DQA1 Intermediate Resolution (2508)
<input type="checkbox"/> HLA-DPB1 Intermediate Resolution (2513)
<input type="checkbox"/> HLA-B/DRB1 Intermediate Resolution (Verification Typing) (2319)
<input type="checkbox"/> HLA-A High Resolution (2324)
<input type="checkbox"/> HLA-B High Resolution (2325)
<input type="checkbox"/> HLA-C High Resolution (2326)
<input type="checkbox"/> HLA-ABC High Resolution (2329)
<input type="checkbox"/> HLA-DRB1 High Resolution (2322)
<input type="checkbox"/> HLA-DQB1 High Resolution (2328)
<input type="checkbox"/> HLA-DPB1 High Resolution (2323)
<input type="checkbox"/> HLA High Resolution Panel by NGS (2300)
<input type="checkbox"/> HLA Haplotype by STR (2380)
<input type="checkbox"/> KIR Genotyping (2377) |
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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 _____
_____ 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 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.