Histocompatibility Lab | Chimerism Testing

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

versiti

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: ☐ Ashkenazi Jewish ☐ Black/African American ☐ Central Asian ☐ East Asian ☐ Hispanic/Latino ☐ Middle Eastern ☐ Native American ☐ South Asian ☐ White ☐ Other _____

Specimen Information

Specimen Type: ☐ Blood ☐ Buccal Swabs ☐ Bone Marrow ☐ DNA ☐ Umbilical Cord Blood ☐ Other _____

Anticoagulant: ☐ EDTA ☐ ACDA ☐ ACDB ☐ Sodium Heparin ☐Other _____	Draw Date:	Draw Time:

Required for All Chimerism Testing (please complete all fields)

Diagnosis:

Previous Transplant?	☐ Yes	Type:	Date:	Transplant Center:
	☐ No	Anticipated Transplant Date:	☐ Bone Marrow ☐ Solid Organ ☐ Other _____	

Sample is from: ☐ Recipient ☐ Prospective Donor

Donor Name:	Donor Date of Birth:
Donor Sex (select one): ☐ Male ☐ Female	Relationship to Recipient:
Recipient Name:	Recipient Date of Birth:
Recipient Sex (select one): ☐ Male ☐ Female	Relationship to Donor:

Chimerism Testing

Pre-Transplant Chimerism Testing
- ☐ Recipient specimen (2640)
- ☐ Donor specimen (2650)

Post-Transplant Chimerism Testing by NGS
- ☐ Chimerism on blood sample (2820)
- ☐ Chimerism on bone marrow (2822)

Chimerism on Enriched Cell Populations
- ☐ CD3 & CD33 cells (2754)
- ☐ CD3 & CD33 & CD56 cells (2755)
- ☐ CD19 & CD56 cells (2756)
- ☐ CD3 cells (2750)
- ☐ CD33 cells (2751)
- ☐ CD19 cells (2752)
- ☐ CD56 cells (2753)

Twin Zygosity
- ☐ Recipient specimen (2680)
- ☐ Donor specimen (2690)

Maternal Cell Chimerism
- ☐ Child buccal specimen (2660)
- ☐ Maternal specimen (2665)
- ☐ Evaluation on child blood sample (2670)
  - ☐ CD3 cells (2770)
  - ☐ CD33 cells (2772)
  - ☐ CD19 cells (2774)
  - ☐ CD56 cells (2776)

Sickle Cell Disease
- ☐ Hemoglobin SC Mutation Analysis (4624)

Erythroid Chimerism
- ☐ Erythroid Chimerism (4250)

Donor Genotype _____ ☐ AA ☐ AS (Required)

Genotype _____ ☐ SS ☐ AS (Required)

STAT Testing

☐ **STAT Testing (STAT Fee Applies)**

Results Required No Later Than: Date Needed By: _____/_____/_____ Time: _____:_____

Contact Name:

Contact Phone #:

VERSITI USE ONLY

___ HEPB ___ ACDA ___ ACDB ___ EDTA

___ Clot ___ Other: _____

Opened By:	Reviewed By:
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.

Cell sort specimens for post-transplant chimerism monitoring must be received within 24 hours of collection to ensure cell viability.

<table>
<tr><th>TEST</th><th>SAMPLE REQUIREMENTS</th><th>STORE & SHIP</th></tr>
<tr><td>Erythroid Chimerism</td><td>3-5 ml EDTA Bone Marrow (lavender top) OR 10 ml EDTA Whole Blood (lavender top)</td><td>Room temperature via an overnight courier. Samples must be received within 48 hours of being drawn.</td></tr>
<tr><td>Hemoglobin SC Mutation Analysis</td><td>FETAL:
7-15 ml Amniotic Fluid or 5-10 mg CVS, backup culture of Amniocytes or CVS is highly recommended;
Two T25 flasks Cultured Amniocytes or CVS (2x10^6 minimum)

PARENTAL & PATIENTS:
3-5 mL EDTA whole blood (lavender top). Maternal sample for maternal cell contamination 1µg DNA (25ng/µl and 25µl)</td><td>Room temperature</td></tr>
<tr><td>Chimerism</td><td>PRE-TRANSPLANT RECIPIENT AND DONOR:
5 ml whole blood or marrow
Collection tube anticoagulants EDTA, Na Heparin, or ACDA
OR
4 cotton buccal swabs each
POST-TRANSPLANT (RECIPIENT):
5 ml whole blood or marrow
Collection tube anticoagulants EDTA, Na Heparin, or ACDA
Cells: Contact Laboratory for requirements</td><td>Room temperature</td></tr>
<tr><td>Cell Sort Enrichment
CD3, CD19, CD33, CD56</td><td>Collection tub anticoagulants EDTA, Na Heparin*, or ACDA
<table>
<tr><th>Cell Enrichment</th><th>Required Volume Blood or Marrow</th></tr>
<tr><td>CD3</td><td>4 ml</td></tr>
<tr><td>CD33</td><td>4 ml</td></tr>
<tr><td>CD3 & CD33</td><td>8 ml</td></tr>
<tr><td>CD19</td><td>8 ml</td></tr>
<tr><td>CD56</td><td>8 ml</td></tr>
<tr><td>CD19 & CD56</td><td>16 ml</td></tr>
<tr><td>CD3 & CD33 & CD56</td><td>16 ml</td></tr>
</table></td><td>Room temperature. Samples must be received within 24 hours of draw and may be drawn Sunday through Thursday for delivery Monday through noon on Friday.</td></tr>
<tr><td>Twin Zygosity</td><td>RECIPIENT AND DONOR:
5 ml EDTA whole blood OR 4 cotton buccal swabs</td><td>Room temperature</td></tr>
<tr><td>Maternal Cell Chimerism</td><td>CHILD (INFORMATIVE AND EVALUATION):
4 cotton buccal swabs AND 2mL whole blood
Collection tube anticoagulants EDTA, Na Heparin or ACDA
MOTHER:
4 cotton buccal swabs OR 5mL whole blood
Collection tube anticoagulants EDTA, Na Heparin or ACDA</td><td>Room temperature</td></tr>
</table>

*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