



Vitalant
HLA Laboratory
 124 W. Thomas Rd. Suite #210 / Phoenix, AZ 85013
 CLIA License #03D1106263
 Phone: 623-487-6400 Fax: 602-279-8240

HLA Requisition Form

Date Of Request _____

Report to: Physician Laboratory Vitalant Center All Contact Person _____

Referring Physician _____

Bill to: Physician Laboratory Vitalant Center Other

Facility Name _____

Name _____

Address _____

Address _____

Phone _____ Fax # _____

Phone # _____ Fax # _____

| | | | | |
|-------------------------------|---|---|--|--|
| Specimen Requirements: | DNA Testing 2x10 mL ACD (Yellow top) or EDTA | Antibody Screen/ID 2x10 mL red top (patient) or EDTA | Auto Crossmatch 2x10 mL red top (patient) 4x10 mL ACD (patient) | Allo Crossmatch 2x10 mL red top (patient) 4x10 mL ACD (donor) |
| Samples Information: | Collection Date/Time _____ <input type="checkbox"/> Blood <input type="checkbox"/> Buccal Swab <input type="checkbox"/> Other _____ | | | |

| Item # | Quantity | Test Description |
|-------------------------|----------|--|
| Molecular Typing | | |
| HL500 | _____ | <input type="checkbox"/> HLA (A, B, C, DR, DQ) HR Patient/Donor Typing |
| HL420 | _____ | <input type="checkbox"/> HLA (A,B,C,DR) IR |
| HL425 | _____ | <input type="checkbox"/> HLA (A, B, DR) IR |
| HL400 | _____ | <input type="checkbox"/> HLA (A, B, C) IR (Intermed Res) |
| HL545 | _____ | <input type="checkbox"/> HLA (A, B, C) HR (High Res) |
| HL415 | _____ | <input type="checkbox"/> HLA (DR, DQ) LR (Low Res) |
| HL550 | _____ | <input type="checkbox"/> HLA (DR, DQ) HR with DRB3/4/5 |
| HL510 | _____ | <input type="checkbox"/> HLA-A HR |
| HL515 | _____ | <input type="checkbox"/> HLA-B HR |
| HL520 | _____ | <input type="checkbox"/> HLA-C HR |
| HL525 | _____ | <input type="checkbox"/> HLA-DRB1 HR |
| HL530 | _____ | <input type="checkbox"/> HLA-DRB3/4/5 HR |
| HL535 | _____ | <input type="checkbox"/> HLA-DQB1 HR |
| HL555 | _____ | <input type="checkbox"/> HLA-DPA1 HR |
| HL540 | _____ | <input type="checkbox"/> HLA-DPB1 HR |
| HL560 | _____ | <input type="checkbox"/> HLA-DQA1 HR |
| HL455 | _____ | <input type="checkbox"/> HLA One Locus IR (Class I) _____ |
| HL460 | _____ | <input type="checkbox"/> HLA One Locus IR (Class II) _____ |
| HL300 | _____ | <input type="checkbox"/> Patient HLA (A,B) IR, for Platelets |
| HL305 | _____ | <input type="checkbox"/> Donor Testing HLA (A, B) for Apheresis |

| Item # | Quantity | Test Description |
|--|----------|--|
| Antibody Identification | | |
| HL100 | _____ | <input type="checkbox"/> HLA Antibody Screen <input type="checkbox"/> Class I ID if Positive <input type="checkbox"/> Class II ID if Positive |
| HL115 | _____ | <input type="checkbox"/> HLA ABY Identification Class I |
| HL120 | _____ | <input type="checkbox"/> HLA ABY Identification Class II |
| HL125 | _____ | <input type="checkbox"/> HLA Antibody Dilution Study Class I |
| HL130 | _____ | <input type="checkbox"/> HLA Antibody Dilution Study Class II |
| HL195 | _____ | <input type="checkbox"/> Other Antibody Tests |
| Crossmatch | | |
| HL200 | _____ | <input type="checkbox"/> HLA Flow Crossmatch |
| HL205 | _____ | <input type="checkbox"/> HLA Flow Crossmatch with Titration |
| Misc Testing | | |
| HL310 | _____ | <input type="checkbox"/> HLA Matched Platelet Donor Search |
| HL600 | _____ | <input type="checkbox"/> Chimerism Studies (Initial Workup) |
| HL610 | _____ | <input type="checkbox"/> Chimerism Studies (Followup Testing) |
| HL700 | _____ | <input type="checkbox"/> Buccal Swab Isolation |
| HL705 | _____ | <input type="checkbox"/> DNA Isolation |
| HL495 | _____ | <input type="checkbox"/> Other IR Typing Tests _____ |
| HL595 | _____ | <input type="checkbox"/> Other HR Typing Tests |
| Testing Priority | | |
| <input type="checkbox"/> Routine <input type="checkbox"/> HL900 ASAP <input type="checkbox"/> HL905 STAT | | |

Patient Information (Recipient)

Last Name _____ First Name _____

Med. Record or SS # _____ NMDP Recipient ID _____

Birthdate _____ Sex: F M Blood Group: A B AB O

Pregnancies: No Yes Qty _____ Transfusions: No Yes Type _____ Qty _____ Dates _____

Disease _____ Transplant Type: Heart Lung Kidney Bone Marrow

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|-----------------------------|
| For HLA Lab use only |
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Donor Information

Last Name _____ First Name _____

Med. Record or SS # _____ NMDP Donor ID _____

Birthdate _____ Sex: F M Blood Group: A B AB O

Relationship _____

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|-----------------------------|
| For HLA Lab use only |
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|---|----------|------------|------------|
| FOR LABORATORY USE ONLY | | | |
| Report sent: (F = Fax, V = Verbal, W = Written, E = Email) | | | |
| <input type="checkbox"/> F <input type="checkbox"/> V <input type="checkbox"/> W <input type="checkbox"/> E | To _____ | Date _____ | Tech _____ |
| <input type="checkbox"/> F <input type="checkbox"/> V <input type="checkbox"/> W <input type="checkbox"/> E | To _____ | Date _____ | Tech _____ |
| <input type="checkbox"/> F <input type="checkbox"/> V <input type="checkbox"/> W <input type="checkbox"/> E | To _____ | Date _____ | Tech _____ |
| Comments _____ | | | |