HLA/IMMUNOGENETICS LABORATORY REQUEST FORM  Please fill out only one request per person.  HLA Req 9/07				
$\bigcirc$	Date:	to request per per	Location:	
Wake Forest University Baptist	Medical Record #:			
MEDICAL CENTER® HLA/Immunogenetics Laboratory	Name:			
145 Kimel Park Drive, Suite 250 Winston-Salem, NC 27103 PHONE: (336) 716-4456	Address:			
FAX: (336) 774-7665		ex:	DOB:	
Information below is REQUIRED!				
ORDERING PHYSICIAN (please print)	Collection Information  Date:		DIAGNOSIS or	ICD-9 CODE
LAST FIRST	Collection Time:			
DR. #: PAGER:	Phlebotomist:			
COORDINATOR:				
HLA TEST(S): Check appropriate box(es)  SOLID ORGAN  BONE MARROW & OTHERS				
☐ KIDNEY ☐ KIDNEY/PANCR	Bone Marro		OTHER Please	
		STEM CEL	L SUPPORT	specify:
TEST TUBE TYPE*		<u>TEST</u>		TUBE TYPE*
☐ <u>HLA TYPING FOR SOLID ORGAN – PATIENT</u>		☐ HLA TYPING FOR BM/STEM CELL – PATIENT		
Tracking in all and an	Patient type Autologous Allogeneic Testing includes:			
<b>Testing includes:</b> HLA-A, -B, -Cw, -DR &-DQ TYPING	HLA-A, -B, &-C; low res. (auto) or high res. (allo.) 2 – Y			
AUTOCROSSMATCH & PRA (Eval. Workup only) 1 – R		HLA-DR & -DQ TYPING high res. (allo only) 2 – Y AUTOCROSSMATCH & PRA 1 – R		
☐ <u>HLA TYPING FOR SOLID ORGAN – DONOR</u>		☐ HLA TYPING FOR BM/STEM CELL – DONOR		
Testing includes: HLA-A, -B, -Cw, -DR &-DQ TYPING	Testing includes: HLA-A, -B, &-DR Will reflex into high resolution HLA-A,-B, -Cw, -DR, & -DQ typing if donor is a potential allelic match			
HLA-A, -B, -Cw, -DR &-DQ TYPING 4 – Y CROSSMATCH WITH RECIPIENT'S SERUM				
DONOR FOR:		DONOR FOR:		
Patient Name	MR#			
RELATIONSHIP TO PT:		RELATIONSHIP TO PT:		
CROSSMATCH (post-evaluation)		CROSSMATCH (post-evaluation)		
□ <u>AUTOCROSSMATCH</u>	2 – Y 1 – R	☐ <u>AUTOCR</u>	OSSMATCH (patient vs. s	elf) 2 – Y 1 – R
☐ CROSSMATCH WITH DONOR	(Donor) 2 – Y (Patient) 1 – R	□ <u>CROSSM</u>	ATCH WITH DONOR	(Donor) 2 – Y (Patient) 1 – R
PRA  ANTI-HLA ANTIBODY TESTING	<b>G (PRA)</b> 1 – R	☐ ANTI-HL	<u>PRA</u> A ANTIBODY TESTINO	<b>G (PRA)</b> 1 – R
			PLATELET SUPPORT TE	ESTING
POST-SENSITIZING EVENT PRA TESTING 1 - F (i.e. nephrectomy, blood transfusion, etc.		☐ HLA TYPING FOR PLATELET SUPPORT 2 - Y or L ☐ ANTI-HLA ANTIBODY TESTING (PRA) I - R		
Please specify Event and Date:			DISEASE ASSOCIATIO	
		Requested lo	cus/loci ne locus requested, a full class I or	Il typing will be performed
		I more than Or		jp.iigii oo pertoriiled

\* Tube Types Legend R - 10 mL Plain Red Y - 10 mL Yellow ACD-A L - 4.5 mL Lavender EDTA Call Lab for Pediatric Minimums