HLA/IMMUNOGENETICS LABORATORY REQUEST FORM

HLA Req 9/07

Please fill out only one request per person.

Wake Forest University Baptist MEDICAL CENTER®
HLA/Immunogenetics Laboratory
145 Kimel Park Drive, Suite 250
Winston-Salem, NC 27103
PHONE: (336) 716-4456
FAX: (336) 774-7665

Date: Location:

Medical Record #:

Name:

Address:

Race: Sex: DOB:

Information below is REQUIRED!

ORDERING PHYSICIAN (please print)

LAST FIRST

DR. #: PAGER:

COORDINATOR:

Collection Information

Date:

Collection Time:

Phlebotomist:

DIAGNOSIS or ICD-9 CODE

HLA TEST(S): Check appropriate box(es)

SOLID ORGAN

☐ KIDNEY ☐ KIDNEY/PANCREAS ☐ HEART

TEST	TUBE TYPE*
☐ **HLA TYPING FOR SOLID ORGAN – PATIENT**	
Testing includes:	
HLA-A, -B, -Cw, -DR &-DQ TYPING	4 – Y
AUTOCROSSMATCH & PRA (Eval. Workup only)	1 – R
☐ **HLA TYPING FOR SOLID ORGAN – DONOR**	
Testing includes:	
HLA-A, -B, -Cw, -DR &-DQ TYPING	4 – Y
CROSSMATCH WITH RECIPIENT'S SERUM	

DONOR FOR: _____
Patient Name MR#

RELATIONSHIP TO PT:

CROSSMATCH (post-evaluation)

☐ **AUTOCROSSMATCH**	2 – Y 1 – R
☐ **CROSSMATCH WITH DONOR**	(Donor) 2 – Y (Patient) 1 – R

PRA

☐ **ANTI-HLA ANTIBODY TESTING (PRA)** 1 – R

☐ **POST-SENSITIZING EVENT PRA TESTING** 1 – R
(i.e. nephrectomy, blood transfusion, etc.

Please specify
Event and Date: _____

BONE MARROW & OTHERS

☐ Bone Marrow/ STEM CELL ☐ PLATELET SUPPORT ☐ OTHER Please specify:

TEST	TUBE TYPE*
☐ **HLA TYPING FOR BM/STEM CELL – PATIENT**	
Patient type Autologous _____ Allogeneic_____	
Testing includes:	
HLA-A, -B, &-C; low res. (auto) or high res. (allo.)	2 – Y
HLA-DR & -DQ TYPING high res. (allo only)	2 – Y
AUTOCROSSMATCH & PRA	1 – R
☐ **HLA TYPING FOR BM/STEM CELL – DONOR**	
Testing includes:	
HLA-A, -B, &-DR	4 – Y or L
Will reflex into high resolution HLA-A,-B, -Cw, -DR, & -DQ typing if donor is a potential allelic match	

DONOR FOR: _____
Patient Name MR#

RELATIONSHIP TO PT:

CROSSMATCH (post-evaluation)

☐ **AUTOCROSSMATCH** (patient vs. self)	2 – Y 1 – R
☐ **CROSSMATCH WITH DONOR**	(Donor) 2 – Y (Patient) 1 – R

PRA

☐ **ANTI-HLA ANTIBODY TESTING (PRA)** 1 – R

PLATELET SUPPORT TESTING

☐ **HLA TYPING FOR PLATELET SUPPORT** 2 – Y or L
☐ **ANTI-HLA ANTIBODY TESTING (PRA)** 1 – R

HLA DISEASE ASSOCIATION TESTING

☐ **HLA SINGLE or MULTI-LOCUS TESTING**** 2 – Y or L

Requested locus/loci _____
** If more than one locus requested, a full class I or II typing will be performed

*** 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