HLA/IMMUNOGENETICS LABORATORY REQUEST FORM

HLA Req 10/15

Please fill out only one request per person.

Wake Forest Baptist Health

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)	**Collection Information**	**DIAGNOSIS or ICD-10 CODE**
LAST FIRST DR. #: PAGER: COORDINATOR:	**Date:** **Collection Time:** **Phlebotomist:**	

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:_____

❑ ***APOL1* GENOTYPING** 2 - Y or L

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