

Versiti does NOT bill patients or their insurance. Call 800-245-3117 ext. 6250 for your Client#.



Histocompatibility Lab-Versiti WI  
Engraftment / Chimerism Testing  
Phone 800-245-3117 x 6201 / Fax (414) 937-6322

Person Completing Requisition:	
Institution:	Client #
Dept:	Physician/Provider:
Address:	
City:	ST: ZIP:
Phone (Lab):	Phone/Email (Provider)
Special Reporting Requests:	PO#:

**MEDICARE**

Is testing for outpatient Medicare enrollee or Wisconsin Medicaid recipient? **Yes**  **No**

If yes, please complete and attach our beneficiary form located at [www.versiti.org/medical-professionals/products-services/requisitions](http://www.versiti.org/medical-professionals/products-services/requisitions)

**PATIENT INFORMATION**

<b>Last Name:</b>	<b>First Name:</b>	<b>MI:</b>	<b>DOB:</b>
<b>MR#:</b>	<b>Accession#:</b>	<b>Draw Date:</b>	
<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		<b>Draw Time:</b>	
<b>Ethnic Background (check all that apply):</b> <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Other			
<b>Specimen Type:</b> <input type="checkbox"/> Blood <input type="checkbox"/> Buccal Swabs <input type="checkbox"/> Bone Marrow <input type="checkbox"/> DNA <input type="checkbox"/> Umbilical Cord Blood <input type="checkbox"/> Other _____			
<b>Anticoagulant:</b> <input type="checkbox"/> EDTA <input type="checkbox"/> ACDA <input type="checkbox"/> ACDB <input type="checkbox"/> Sodium Heparin <input type="checkbox"/> Other _____			

**REQUIRED FOR ALL ENGRAFTMENT 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 Donor Name: \_\_\_\_\_ Donor Date of Birth: \_\_\_\_\_

Donor Sex (Circle One): M or F Relationship to Recipient: \_\_\_\_\_

Donor Recipient Name: \_\_\_\_\_ Recipient Date of Birth: \_\_\_\_\_

Recipient Sex (Circle One): M or F Relationship to Donor: \_\_\_\_\_

**Tests**

Pre-Transplant Engraftment/Chimerism Testing	Post-Transplant Engraftment/Chimerism Testing	
<input type="checkbox"/> Recipient specimen (4020) <input type="checkbox"/> Donor specimen (4040)	<input type="checkbox"/> Engraftment on <u>blood</u> sample (4220) <input type="checkbox"/> Engraftment on <u>bone marrow</u> (4222)	
<b>Twin Zygoty Testing</b>	<b>Engraftment/Chimerism on Enriched Cell Populations</b>	
<input type="checkbox"/> Recipient specimen (4060) <input type="checkbox"/> Donor specimen (4070)	<input type="checkbox"/> CD3 & CD33 cells (2044) <input type="checkbox"/> CD3 & CD33 & CD56 cells (2045) <input type="checkbox"/> CD19 & CD56 cells (2046) <input type="checkbox"/> CD3 cells (2040) <input type="checkbox"/> CD33 cells (2041) <input type="checkbox"/> CD19 cells (2042) <input type="checkbox"/> CD56 cells (2043)	
<b>Erythroid Chimerism</b>	<b>Engraftment on Other Sample Types:</b>	
<input type="checkbox"/> Erythroid Chimerism (4250) <b>Donor Genotype</b> _____ <input type="checkbox"/> AA <input type="checkbox"/> AS (Required) <b>Genotype</b> _____ <input type="checkbox"/> SS <input type="checkbox"/> AS (Required)	<input type="checkbox"/> Prepare MNC, chimerism (2048)	
<b>Sickle Cell Disease</b>	<b>STAT TESTING</b>	<b>Versiti Use Only</b>
<input type="checkbox"/> Hemoglobin SC Mutation Analysis (4624)	<input type="checkbox"/> <b>STAT Testing</b> <b>(Fee required)</b> <b>Results Required By:</b> <b>Date:</b> _____ <b>Time:</b> _____ <i>Timeframe for results:</i> Blood/BM - 48 hrs   Sorted cells - 72 hrs	___ ACDA HEPB ___ ACDB buccal swabs ___ EDTA ___ Other: _____ Opened By: _____ Evaluated By: _____ Reviewed By: _____ Labeled By: _____

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Tubes must be **individually** labeled with the **FULL NAME OF THE INDIVIDUAL, ANOTHER IDENTIFIER (e.g., SSN, MRN, DOB), DATE AND TIME OF COLLECTION.**

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 12:00pm 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.**

Test	Sample Type	Store and Ship												
Erythroid Chimerism	3-5 mL EDTA Bone Marrow (lavender top) OR 10 mL EDTA Whole Blood (lavender top)	Room temperature via an overnight courier. Samples must be received within 48 hours of being drawn.												
Hemoglobin SC Mutation Analysis	<b>FETAL:</b> 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 <sup>6</sup> minimum) <b>PARENTAL &amp; PATIENTS:</b> 3-5 mL EDTA whole blood (lavender top). Maternal sample for maternal cell contamination 1µg DNA (25ng/µl and 25µl)	Room temperature.												
Engraftment/Chimerism	<b>Pre-transplant Recipient and Donor:</b> •5 ml whole blood or marrow •Collection tube anticoagulants EDTA, Na Heparin, or ACDA OR •4-8 Buccal swabs each <b>Post-transplant (Recipient):</b> •5 ml whole blood or marrow •Collection tube anticoagulants EDTA, Na Heparin, or ACDA •Cells: Contact Laboratory for requirements	Room temperature.												
Cell Sort Enrichment CD3, CD19, CD33, CD56	<ul style="list-style-type: none"> <li>•Collection tube anticoagulants EDTA, Na Heparin, or ACDA</li> </ul> <table border="1"> <thead> <tr> <th>Cell Enrichment</th> <th>Required Volume Blood or Marrow</th> </tr> </thead> <tbody> <tr> <td>CD3 or CD33</td> <td>4ml</td> </tr> <tr> <td>CD3 &amp; CD33</td> <td>8ml</td> </tr> <tr> <td>CD19 or CD56</td> <td>8ml</td> </tr> <tr> <td>CD19 &amp; CD56</td> <td>16ml</td> </tr> <tr> <td>CD3 &amp; CD33 &amp; CD56</td> <td>16ml</td> </tr> </tbody> </table>	Cell Enrichment	Required Volume Blood or Marrow	CD3 or CD33	4ml	CD3 & CD33	8ml	CD19 or CD56	8ml	CD19 & CD56	16ml	CD3 & CD33 & CD56	16ml	Room temperature. Samples must be received within 24 hours of draw and may be drawn Monday through Thursday for delivery Tuesday through Friday.
Cell Enrichment	Required Volume Blood or Marrow													
CD3 or CD33	4ml													
CD3 & CD33	8ml													
CD19 or CD56	8ml													
CD19 & CD56	16ml													
CD3 & CD33 & CD56	16ml													
Twin Zygosity	5 mL EDTA whole blood or bone marrow OR 4-8 Buccal	Room temperature												

Blood samples should be shipped by overnight carrier. The package must be shipped in compliance with carrier's guidelines. Please contact your carrier for current biohazardous shipping regulations.

**Shipping address:** Versiti Wisconsin – Histocompatibility Laboratory  
638 N. 18th Street  
Milwaukee, WI 53233  
Phone: (414) 937-6201

Label Box: Refrigerate, Room Temperature, or Frozen (whichever is appropriate)