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

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

Histocompatibility Lab
LOH Requisition
Phone 800-245-3117 x6250
Fax 414-937-6322

Patient/Sample Name	Last		First		MI		
MR #		Accession #					
DOB	/ /	Gender	☐ M ☐ F	Draw Date	/ /		
Specimen Type	☐ Sodium Heparin Blood ☐ Sodium Heparin Bone Marrow ☐ Buccal Swabs ☐ DNA ☐ Other			Draw Time			
Ethnicity	☐ Caucasian ☐ African American ☐ Hispanic/Latino ☐ Asian ☐ Ashkenazi Jewish ☐ Other						

Medicare

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

If yes, please complete our beneficiary form located at www.versiti.org/medical-professionals/products-services/requisitions and submit with this requisition

Relapse Information

Primary Disease_____Blast%_____Relapse analysis date performed_____

Note: Test requires fresh blood or bone marrow collection during active relapse with blast counts ideally 5% or greater

Previous Therapies:

☐ HLA Matched Allogeneic Transplant: Donor Name_____Donor DOB_____

☐ HLA Mismatched Allogeneic Transplant: Donor Name_____Donor DOB_____

☐ Autologous CAR-T ☐ Allogeneic CAR-T ☐ Other cellular therapy

DRAWING INSTRUCTIONS: Tubes must be individually labeled with **FULL NAME OF INDIVIDUAL, DOB, and DATE & TIME OF DRAW**. Urgent testing **MUST** be arranged through the laboratory by calling 1-800-245-3117, ext. 6250.

HLA Loss of Heterozygosity Evaluation Test #2722

☐ Peripheral blood (5-10ml Na heparin/ Green top)

☐ Bone marrow (2-3ml Na heparin /Green top)
NOTE: Store sample ambient. Sample must be received within 72 hours of collection.

Ship ambient with overnight carriers
Monday-Friday to:
Hematologics Inc
3161 Elliott Ave
Suite 200
Seattle, WA 98121
Phone: (800) 860-0934 or (206) 223-2700

HLA LOH Patient Germline (Add-on) #2720

*Required if pre-transplant testing done outside of Versiti

1) ☐ Fresh buccal sample [Preferred] (4 or more swabs) OR

☐ DNA(100ul @ 20ng/ul) - Pre-transplant patient sample

2) HLA Typing reports on patient & donor

Options for delivery to Versiti:

☐ Printed copies in sample shipment [Preferred]

☐ Encrypted email to HLASequencing@versiti.org

☐ FAX to 414-937-6322

Ship ambient with overnight carriers Monday-Friday to:
Versiti Wisconsin – Histocompatibility Laboratory
638 N. 18th Street
Milwaukee, WI 53233
Phone: (414) 937-6201

Hematologics Processing Only	Versiti Use Only	
_____	___Buccal ___DNA ___Heparin ___Other_____	Opened By_____ Evaluated By_____ Reviewed By_____ Labeled By_____