

Histocompatibility Lab | Transplant Testing

Phone: 800-245-3117 x6250 | Fax 414-937-6322



NOTE: Versiti does NOT bill patients or insurance. Test orders must be placed through a medical facility that has an account with Versiti. Client # required.

Ordering Institution Information			
Person Completing Requisition:		Physician/Provider:	
Institution:		Client #:	
Dept:		Address:	
City:		State:	Zip Code:
Phone (Lab):		Provider Contact (phone/email):	
Special Reporting Requests:			PO #:
Is testing for outpatient Medicare enrollee or Wisconsin Medicaid recipient? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete the beneficiary form located at https://versiti.org/products-services/requisitions and submit with this requisition.			
Patient Information			
Last Name:		First Name:	MI: DOB:
MR#:	Accession #:		SSN:
Biologic Sex/Sex Assigned at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		Ethnicity: <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Other _____	
Specimen Information			
Specimen Type: <input type="checkbox"/> Blood <input type="checkbox"/> Buccal Swabs <input type="checkbox"/> Plasma <input type="checkbox"/> Serum <input type="checkbox"/> DNA <input type="checkbox"/> Umbilical Cord Blood <input type="checkbox"/> Other _____			
Anticoagulant: <input type="checkbox"/> EDTA <input type="checkbox"/> ACDA <input type="checkbox"/> ACDB <input type="checkbox"/> Clot <input type="checkbox"/> Sodium Heparin <input type="checkbox"/> Other _____			Draw Date: Draw Time:
Patient History			
Transfusion History: <input type="checkbox"/> Unknown <input type="checkbox"/> None <input type="checkbox"/> Multiple _____ (number)		Last Transfusion: ____/____/____ of: _____	
Diagnosis:		Previous Typing, If Known:	
HLA-A _____ HLA-B _____ HLA-C _____ HLA-DR _____ HLA-DQ _____ HLA-DP _____			
Transplant Workup			
Type: <input type="checkbox"/> Bone Marrow (Stem Cell) <input type="checkbox"/> Kidney <input type="checkbox"/> Pancreas <input type="checkbox"/> Liver <input type="checkbox"/> Heart <input type="checkbox"/> Lung <input type="checkbox"/> Deceased Organ Donor <input type="checkbox"/> Other _____			
Required For Transplant Recipients			
Coordinator Name:		Phone #:	
Previous Transplant? <input type="checkbox"/> No <input type="checkbox"/> Yes Type:		Date: ____/____/____	Transplant Center:
Number of pregnancies (including miscarriages and abortions):			
Sample is from: <input type="checkbox"/> Recipient <input type="checkbox"/> Prospective Donor		Name of Recipient:	
Relationship to Recipient:		Recipient's Transplant Center:	
Transplant Testing			
<input type="checkbox"/> ABO/Rh (2200) <input type="checkbox"/> Autocrossmatch (Flow Cytometric Crossmatch) (2600) <input type="checkbox"/> Crossmatch (Flow Cytometric Crossmatch with Recipient) (2610) <input type="checkbox"/> Crossmatch Titration (Flow Cytometry) (2601) <input type="checkbox"/> HLA Antibody Detection (Flow Cytometry) (2235) <input type="checkbox"/> HLA Antibody Identification Class I High Resolution (2226) <input type="checkbox"/> HLA Antibody Identification Class II High Resolution (2231) <input type="checkbox"/> HLA Antibody Identification Class I Dilution - High Resolution (2225) <input type="checkbox"/> HLA Antibody Identification Class II Dilution - High Resolution (2230) <input type="checkbox"/> HLA-A Low Resolution (2304) <input type="checkbox"/> HLA-B Low Resolution (2305) <input type="checkbox"/> HLA-C Low Resolution (2306) <input type="checkbox"/> HLA-AB Low Resolution (2303) <input type="checkbox"/> HLA-ABC Low Resolution (2302) <input type="checkbox"/> HLA-DRB1 Low Resolution (2307) <input type="checkbox"/> HLA-DRB3, B4, B5 Low Resolution (2122) <input type="checkbox"/> HLA-DRB1 and -DQB1/-DQA1 Low Resolution (2553) <input type="checkbox"/> HLA-DQB1/-DQA1 Low Resolution (2308) <input type="checkbox"/> HLA-DPB1/-DPA1 Low Resolution (2318) <input type="checkbox"/> HLA-A Intermediate Resolution (2504) <input type="checkbox"/> HLA-B Intermediate Resolution (2505) <input type="checkbox"/> HLA-C Intermediate Resolution (2506) <input type="checkbox"/> HLA-AB Intermediate Resolution (2520) <input type="checkbox"/> HLA-ABC Intermediate Resolution (2347) <input type="checkbox"/> HLA-A, B, DRB1 Intermediate Resolution (2522) <input type="checkbox"/> HLA-DRB1 Intermediate Resolution (2507) <input type="checkbox"/> HLA-DRB3, B4, B5 Intermediate Resolution (2321) <input type="checkbox"/> HLA-DQB1/-DQA1 Intermediate Resolution (2508) <input type="checkbox"/> HLA-DPB1/-DPA1 Intermediate Resolution (2513) <input type="checkbox"/> HLA-B/DRB1 Intermediate Resolution (Verification Typing) (2319) <input type="checkbox"/> HLA-A High Resolution (2324) <input type="checkbox"/> HLA-B High Resolution (2325) <input type="checkbox"/> HLA-C High Resolution (2326) <input type="checkbox"/> HLA-ABC High Resolution (2329) <input type="checkbox"/> HLA-DRB1 High Resolution (2322) <input type="checkbox"/> HLA-DQB1 High Resolution (2328) <input type="checkbox"/> HLA-DPB1 High Resolution (2323) <input type="checkbox"/> HLA High Resolution Panel by NGS (2300) <input type="checkbox"/> HLA Haplotype by STR (2380) <input type="checkbox"/> KIR Genotyping (2377)			
STAT Testing		VERSITI USE ONLY	
<input type="checkbox"/> STAT Testing (STAT Fee Applies)		____ HEPB ____ ACDA ____ ACDB ____ EDTA ____ Clot ____ Other:	
Results Required No Later Than: Date Needed By: ____/____/____ Time: ____:____			
Contact Name:	Opened By:		Reviewed By:
Contact Phone #:	Evaluated By:		Labeled By:

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DRAWING INSTRUCTIONS

Tubes must be **individually** labeled with **FULL NAME OF INDIVIDUAL, ANOTHER IDENTIFIER (e.g., SSN, MRN, DOB), DATE AND TIME OF DRAWING**. 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 noon on Friday**. Emergency testing **MUST** be arranged through the laboratory. Call (414) 937-6201.

TEST	SAMPLE REQUIREMENTS	STORE & SHIP
HLA Antibody Detection & Identification, Kidney recipient monthly HLA antibody	10-ml Clotted (red top) blood (pre-dialysis for kidney recipient HLA antibody testing)	Room temperature
Kidney, Heart, Liver, Pancreas, Lung Recipient - Initial Workup	20-ml Clotted (red top) blood and 14 ml EDTA (lavender top) blood Must be drawn pre-dialysis	Room temperature
Kidney Donor Workup	40-ml Sodium Heparinized whole blood (green top)* and 20-ml Clotted (red top) blood and 14 ml EDTA (lavender top) blood If crossmatches are to be performed, a 10-ml Clotted (red top) sample from recipient is required.	Room temperature
Flow Cytometry Crossmatch*	40-ml ACD solution B (yellow top)* and 10 ml Clotted (red top) If crossmatches are to be performed, a 10-ml Clotted (red top) sample from recipient is required.	Room temperature
Crossmatch Titration (flow cytometry)*	60-ml ACD solution B (yellow top)* and 10 ml Clotted (red top) If crossmatches are to be performed, a 10-ml Clotted (red top) sample from recipient is required.	Room temperature
HLA Low or Intermediate or High Resolution (A, B, C, AB, ABC, DRB1, DRB3,B4,B5, DQB1, DQB1/DQA1, DPB1)	14-ml EDTA (lavender top) whole blood or 4 buccal swabs (contact laboratory if submitting cord blood)	Room temperature
HLA Haplotype by STR or KIR Genotyping	5-ml EDTA (lavender top) whole blood or 4 buccal swabs (contact laboratory if submitting cord blood or purified DNA)	Room Temperature

*Sodium Heparin whole blood is acceptable if received within 24 hours of draw.

SHIPPING INFORMATION

Contact laboratory for pediatric drawing requirements or low white cell count drawing requirements. 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.

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

Packages should be addressed to:

**Versiti Wisconsin – Histocompatibility Laboratory
638 N 18th Street
Milwaukee, WI 53233**