CALGARY HISTOCOMPATIBILITY AND IMMUNOGENETICS (HIL) REQUISITION

Alberta Health Care card AND one other form on government issued identification MUST be presented at each visit

ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

Histocompatibility and Immunogenetics
Diagnostic and Scientific Centre
3520 Research Way NW Calgary, Alberta T2L 2K5
Tel: 403-770-3652 Fax: 403-270-4315

Scanning Label or Accession # (*lab only*)

Patient

PHN Expiry:_____		Date of Birth (*dd-Mon-yyyy*)	
Legal Last Name		Legal First Name	Alternate Identifier
Middle Name	Preferred Name	☐ Male ☐ Female ☐ X Non-binary/Prefer not to disclose	Phone
Address		City/Town	Prov / Postal Code

Provider(s)

Authorizing Provider Name (*last, first, middle*)			Copy to Name (*last, first, middle*)	Copy to Name (*last, first, middle*)
Address		Phone	Address	Address
CC Provider ID	CC Submitter ID	Legacy ID	Phone	Phone
Clinic ID			Clinic ID	Clinic ID

Collection	Date (*dd-Mon-yyyy*)	Time (*24 hr*)	Location	Collector ID

PATIENT INFORMATION & TEST REQUISITION MUST BE COMPLETED TO ENSURE ACCURATE TESTING & INTERPRETATION

HEMATOPOIETIC STEM CELL TRANSPLANT

RECIPIENT: **Specimen Requirements**

Diagnosis:_____

Transfusions: ☐NO ☐YES Date:_____

NOTE: For all Antibody Screening—If drug therapy given, indicate drug:

☐ Thymoglobulin (ATG) ☐ Alemtuzumab ☐ Rituximab ☐ IVIG ☐ Other:_____

☐	**HLABMTPTHR**	**Bone Marrow Recipient Typing – High Resolution** ☐ **Retyping** Connect Care Name: Bone Marrow Recipient – High Res HLA Typing [LAB6050]	2 x 8.5 mL ACD-A tube
☐	**HLABMTPT**	**Bone Marrow Recipient Typing** Connect Care Name: Bone Marrow Recipient Typing – Buccal Swab [LAB6049]	4 x buccal swabs
☐	**HLABMTPTVT**	**Bone Marrow Recipient Typing – Verification** Connect Care Name: Bone Marrow Recipient Verification HLA Typing [LAB6055]	2 x 8.5 mL ACD-A tube
☐	**HLAPLTAB**	**Screen for HLA Platelet Antibodies** Connect Care Name: HSCT – HLA Antibody Investigation [LAB6067]	2 x 4 mL red top tube
☐	**HLAPLTABT**	**HLA Typing for Positive Platelet Antibody Screens** Connect Care Name: Not Applicable	2 x 8.5 mL ACD-A tube

DONOR: **Specimen Requirements**

Intended Recipient: Name _____

PHN/MRN _____

☐	**HLABMTSIB**	**Bone Marrow Donor Typing – Sibling** ☐ **Recipient Out of Province** Connect Care Name: Bone Marrow Donor HLA Typing – Sibling [LAB6053]	2 x 8.5 mL ACD-A tube
☐	**HLABMTNONSIB**	**Bone Marrow Donor Typing – Non-Sibling** **Relationship:** _____ Connect Care Name: Bone Marrow Donor HLA Typing – Non-Sibling [LAB6054]	2 x 8.5 mL ACD-A tube
☐	**HLABMTDVT**	**Bone Marrow Donor Typing – Verification** Connect Care Name: Bone Marrow Donor Verification HLA Typing [LAB6056]	2 x 8.5 mL ACD-A tube
☐	**HLABMTMUD**	**Bone Marrow Donor Typing – Unrelated** Connect Care Name: Bone Marrow HLA Typing – Unrelated [LAB6052]	2 x 8.5 mL ACD-A tube