

HISTOCOMPATIBILITY AND IMMUNOGENETICS (HIL)/TISSUE TYPING REQUISITION

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

Patient	PHN		Alternate Identifier		Date of Birth (yyyy-mm-dd)	
	Last Name		First Name		Middle	Gender <input type="checkbox"/> M <input type="checkbox"/> F
	Address		City/Town		Prov	Postal Code
Requestor(s)	Requestor Name <small>(last,first)</small>		Copy to <small>(last,first)</small>		Copy to <small>(last,first)</small>	
	Location/Facility/Address		Location/Facility/Address		Location/Facility/Address	
	Phone		Phone		Phone	
	Healthcare Provider ID		Healthcare Provider ID		Healthcare Provider ID	
Collection	Date (yyyy-mm-dd)		Time	Location		Collector ID

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

SOLID ORGAN TRANSPLANT

RECIPIENT: Specimen Requirements

Diagnosis: _____

Transfusions: NO YES Date: _____ Prev. Transplants: NO YES Date: _____ Prev. Pregnancies: NO YES Nbr: _____

NOTE: For all Antibody Screening—If drug therapy given, indicate drug:
 Thymoglobulin (ATG) Alemtuzumab Rituximab IVIG Other: _____

<input type="checkbox"/>	HLASOR	Solid Organ Transplant Testing – New Patient ALTRA ID: _____ includes: • HLA-A, B, C, DR, and DQ medium resolution • Antibody screen and single antigen identification	2 x 8.5 mL ACD-A tube 2 x 4 mL red top tube
<input type="checkbox"/>	HLASORXMP	Transplant Recipient Preliminary Crossmatch – By Appointment Only	4 x 8.5 mL ACD-A tube 2 x 4 mL red top tube
<input type="checkbox"/>	HLASORXMF	Transplant Recipient Final Crossmatch – By Appointment Only Date of Surgery: _____	4 x 8.5 mL ACD-A tube 2 x 4 mL red top tube
<input type="checkbox"/>	HLASORRT	Solid Organ Transplant Recipient Retyping includes: • HLA-A, B, C, DR, and DQ medium resolution	2 x 8.5 mL ACD-A tube

ANTIBODY TESTING:

<input type="checkbox"/>	HLASORAB	Solid Organ Transplant Antibody Screen	2 x 4 mL red top tube
<input type="checkbox"/>	HLASORABP	Post-Transplant Antibody Monitoring	2 x 4 mL red top tube
<input type="checkbox"/>	HLASORABBX	Solid Organ Biopsy Antibody Monitoring Date of Biopsy: _____	2 x 4 mL red top tube

LIVING DONOR:

Intended Recipient: Name or ALTRA ID _____ **Anonymous Donor**
 PHN/MRN _____
 Relationship _____

<input type="checkbox"/>	HLASODT	Solid Organ Transplant Donor Typing ALTRA ID: _____ includes: • HLA-A, B, C, DR, and DQ medium resolution	2 x 8.5 mL ACD-A tube
<input type="checkbox"/>	HLASODXMP	Transplant Donor Preliminary Crossmatch – By Appointment Only	4 x 8.5 mL ACD-A tube
<input type="checkbox"/>	HLASODXMF	Transplant Donor Final Crossmatch – By Appointment Only Date of Surgery: _____	6 x 8.5 mL ACD-A tube

DECEASED DONOR:

<input type="checkbox"/>	HLASODD	Solid Organ Transplant Deceased Donor ALTRA ID: _____	8 x 8.5 mL ACD-A tube
<input type="checkbox"/>	HLASODDT	Solid Organ Transplant Deceased Donor Tissue Sample <input type="checkbox"/> Spleen <input type="checkbox"/> Lymph Nodes	Tissue sample in nutrient medium

Shipping Information: Diagnostic and Scientific Centre (DSC) Loading Dock 3520 Research Way NW Calgary, AB T2L 2K5 Tel: (403) 770-3652 Fax: 770-3743	Accession Number
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