



Histocompatibility Requisition
 LABORATORY MEDICINE AND PATHOLOGY
 Client Response Centre 780-407-7484
 CAPITAL HEALTH REGION LABORATORIES
 DynaLIFE_{dx} DIAGNOSTIC LABORATORY SERVICES

Accession #	Specimen Event Type IA <input type="checkbox"/> AUXILLARY IP <input type="checkbox"/> IN PT OP <input type="checkbox"/> OUT PT AP <input type="checkbox"/> AMBUL HC <input type="checkbox"/> HMCARE ST <input type="checkbox"/> STAFF EN <input type="checkbox"/> ENVIRON WCB <input type="checkbox"/> WORKER'S COMP	Bill Type CPL <input type="checkbox"/> Alberta Health Care CCO <input type="checkbox"/> Capital Health Company CO <input type="checkbox"/> Company XX <input type="checkbox"/> Pre-paid OT <input type="checkbox"/> Out of Province PB <input type="checkbox"/> Patient Bill
Chart #		Co. name _____
Lab #		Address _____
		Client # _____

Patient	PHN _____	Alternate Identifier _____		Date of Birth (yyyy-Mon-dd) _____	
	Last Name _____	First Name _____	Middle _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Phone _____
	Address _____	City/Town _____	Province _____	Postal Code _____	Location _____
Requestor(s)	Requestor Name (last, first) _____	Copy to Name (last, first) _____	Copy to Name (last, first) _____		
	Location/Facility/Address _____	Location/Facility/Address _____	Location/Facility/Address _____		
	Phone _____	Phone _____	Phone _____		
	Healthcare Provider ID _____	Healthcare Provider ID _____	Healthcare Provider ID _____		
Collection	Date (yyyy-Mon-dd) _____	Time (24 hr) _____	Location _____	Collector ID _____	

Client Information

Transplant Recipients / Donors	HLA Typing	Deceased Donor Request (HOPE)
<p>NOTE: For all Antibody Screening and Crossmatching: if drug therapy given, indicate drug: <input type="checkbox"/> Thymoglobulin <input type="checkbox"/> Rituximab <input type="checkbox"/> Alemtuzumab <input type="checkbox"/> IVIG Other (specify) _____ Date(s) of therapy _____</p> <p>HLA Antibody Screening Incomplete information may result in sample being stored and not tested. SSTO <input type="checkbox"/> Serum storage only LAS <input type="checkbox"/> Routine HLA Antibody Screen Transfusions <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date(s) _____ Previous Transplants <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date(s) _____ LAS <input type="checkbox"/> Graft Dysfunction TX Biopsy proven rejection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending LAS <input type="checkbox"/> Post Tx Testing with known DSA Indicate date(s) of known DSA _____</p>	<p>HLA Typing for Transplant HLAAD <input type="checkbox"/> HLA Class I / II (ABC, DRB1, DR345, DQA/B, DPA/B) Recipient / Donor (circle)</p> <p>Disease Association Please note many disease associations with HLA antigens are weak. Results can be used to support diagnosis but should be used in conjunction with other clinical diagnostic criteria. HLAAD <input type="checkbox"/> HLA Typing Name of locus/allele requested: _____ Note: Final locus typed will be decided by HLA Lab. Sample will be stored and not tested if clinical information is not supplied) Name of disease _____ Specify HLA antigen(s) associated with disease _____ Contact info of requesting physician _____</p>	<p>Name of HOPE Co-ordinator _____</p> <p>Donor DDD# _____</p> <p>DOB (yyyy-Mon-dd) _____</p> <p>Type and number of Transfusions _____</p> <p>Blood group (ABO) _____</p> <p>Please indicate race for HLA Typing purposes: <input type="checkbox"/> Aboriginal <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Other (specify) _____</p> <p>HLACD <input type="checkbox"/> HLA Typing (Local Deceased Donor)</p> <p>HLASP <input type="checkbox"/> Retrieval Specimen Specimen Type <input type="checkbox"/> spleen <input type="checkbox"/> node <input type="checkbox"/> blood</p> <p>Potential recipients must be indicated, if known:</p> <p>Organ Recipient Name and ULI</p> <p><input type="checkbox"/> Kidney _____ <input type="checkbox"/> Kidney _____ <input type="checkbox"/> Kidney / pancreas _____ <input type="checkbox"/> Islet cell _____ <input type="checkbox"/> Liver _____ <input type="checkbox"/> Heart _____ <input type="checkbox"/> Lung _____ <input type="checkbox"/> Lung _____ <input type="checkbox"/> Small Bowel _____</p> <p>HLA Typing (if typed elsewhere) _____ _____</p>
<p>Crossmatches</p> <p>All routine crossmatches MUST be booked with LDS 780-407-8698. The HLA Lab must be informed of any STAT crossmatches.</p> <p>Relationship of donor to recipient <i>(if spouse/partner, indicate any previous pregnancies with potential donor)</i> _____</p> <p>If donor, name of recipient: _____</p> <p>ULI of recipient: _____</p> <p>TBXM <input type="checkbox"/> T / B crossmatch RTX <input type="checkbox"/> T / B crossmatch (Renal pre-deceased donor only)</p>	<p>Drug Sensitivity</p> <p>B5701 <input type="checkbox"/> HLA B*57:01 Note: Abacavir Hypersensitivity Other <input type="checkbox"/> Indicate disease and name of locus/allele to be tested _____</p> <p>Platelets</p> <p>For ALL indications, provide clinical history and current platelet count _____</p> <p>PLTRE <input type="checkbox"/> Refractory to platelet transfusion – ensure a valid 1-hour post-transfusion platelet count has been obtained PLTNA <input type="checkbox"/> Neonatal alloimmune thrombocytopenia (NAIT) PLTPT <input type="checkbox"/> Post-transfusion purpura (PTP)</p>	<p>Transfusion Reactions</p> <p>HLAM <input type="checkbox"/> TRALI</p>

HLA Laboratory hours Monday - Friday (excluding stat holidays) 7 am - 11:15 pm. Telephone 780-407-8881.
Please ensure the Histocompatibility Requisition accompanies the specimen(s) collected.