Histocompatibility Lab | LOH Testing Requisition

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? Yes 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: Male Female Other

Ethnicity: ☐ Ashkenazi Jewish ☐ Black/African American ☐ Central Asian ☐ East Asian ☐ Hispanic/Latino ☐ Middle Eastern ☐ Native American ☐ South Asian ☐ White ☐ Other _____

Specimen Information

Specimen Type: ☐ Sodium Heparin Blood ☐ Sodium Heparin Bone Marrow ☐ Buccal Swabs ☐ DNA ☐ Other _____

Draw Date:

Draw Time:

Relapse Information (REQUIRED)

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, ANOTHER IDENTIFIER (e.g., SSN, MRN, DOB), DATE AND TIME OF DRAWING**. Urgent testing **MUST** be arranged through the laboratory by calling 1-800-245-3117, ext. 6250.

Testing

HLA Loss of Heterozygosity Evaluation Test #2722

Store ambient. Sample MUST be received within 72 hours of collection.

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

OR

☐ **Bone marrow** (2-3ml Na heparin / Green top)

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 and 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

Request LOH Buccal Kits at versiti.org/lohkit

HEMATOLOGICS PROCESSING ONLY	VERSITI USE ONLY	
	____ Buccal ____ DNA	
	____ Other: _____	
	Opened By:	Reviewed By:
	Evaluated By:	Labeled By:

HLA Loss of Heterozygosity Ordering Instructions

Complete two requisitions.
Send one with active relapse sample (blood or bone marrow) to **Hematologics**
AND
one with buccal sample (4+ swabs) and HLA typing reports to **Versiti**.

1

Collect peripheral blood or bone marrow sample with >5% blast count from patient.

Send sample and requisition to Hematologics. *Sample must be received within 72 hours of collection and be shipped ambient.*

2

Collect buccal sample (4+ swabs) from patient. Prepare HLA typing reports for patient and donor.

Send sample, requisition and HLA typing reports on patient and donor to Versiti. *Sample must be shipped ambient.*