

Histocompatibility Lab | Non-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"/> Ashkenazi Jewish <input type="checkbox"/> Black/African American <input type="checkbox"/> Central Asian <input type="checkbox"/> East Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Native American <input type="checkbox"/> South Asian <input type="checkbox"/> White <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"/> Other _____		Draw Date:	Draw Time:
Patient History			
Potential Platelet Recipient? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete information below **Determine if STAT testing is required and alert Histocompatibility Lab if STAT testing is required (refer to bottom left section and drawing instructions on back/next page).			
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 _____			
Testing			
HLA Matched Platelet Transfusion Workup			
<input type="checkbox"/> HLA-AB Low Resolution (2303)		<input type="checkbox"/> STAT Testing (STAT Fee Applies) – complete bottom left section	
<input type="checkbox"/> HLA Antibody Identification Class I High Resolution (2226)			
HLA Typing			
<input type="checkbox"/> HLA-A Low Resolution (2304)	<input type="checkbox"/> HLA-DRB1 and -DQA1/-DQB1 Low Resolution (2553)	<input type="checkbox"/> HLA-ABC High Resolution (2329)	
<input type="checkbox"/> HLA-B Low Resolution (2305)	<input type="checkbox"/> HLA-DQA1/-DQB1 Low Resolution (2308)	<input type="checkbox"/> HLA-DRB1 High Resolution by DNA Sequencing (2322)	
<input type="checkbox"/> HLA-C Low Resolution (2306)	<input type="checkbox"/> HLA-DPB1/-DPA1 Low Resolution (2318)	<input type="checkbox"/> HLA-DRB3*01 (DR52) Determination (5252)	
<input type="checkbox"/> HLA-ABC Low Resolution (2302)	<input type="checkbox"/> HLA-A High Resolution by DNA Sequencing (2324)	<input type="checkbox"/> HLA-DQB1 High Resolution by DNA Sequencing (2328)	
<input type="checkbox"/> HLA-DRB1 Low Resolution (2307)	<input type="checkbox"/> HLA-B High Resolution by DNA Sequencing (2325)	<input type="checkbox"/> HLA-DPB1 High Resolution by DNA Sequencing (2323)	
<input type="checkbox"/> HLA-DRB3, B4, B5 Low Resolution (2122)	<input type="checkbox"/> HLA-C High Resolution by DNA Sequencing (2326)		
HLA Disease Association Testing			
<input type="checkbox"/> HLA-A*02:01 Determination (2279)	<input type="checkbox"/> HLA-B51 Determination (2275)	<input type="checkbox"/> HLA-DR Single Antigen (2361) Specify: _____	
<input type="checkbox"/> HLA-A29 Determination (2274)	<input type="checkbox"/> HLA-B*15:02 Determination (2276)	<input type="checkbox"/> HLA Typing for Narcolepsy (2270)	
<input type="checkbox"/> HLA-B27 Determination (2271)	<input type="checkbox"/> HLA-B*57:01 Determination (2272)	<input type="checkbox"/> HLA Typing for Celiac Disease (2277)	
HLA Antibody Testing			
<input type="checkbox"/> HLA Antibody Detection (Flow Cytometry) (2235) (If positive, will reflex to HLA Antibody ID Class I / II)		<input type="checkbox"/> HLA Antibody Identification Class I High Resolution (2226) <input type="checkbox"/> HLA Antibody Identification Class II High Resolution (2231)	
STAT Testing		VERSITI USE ONLY	
<input type="checkbox"/> STAT Testing (STAT Fee Applies)		____ HEPB ____ ACDA ____ ACDB ____ EDTA	
Results Required No Later Than: Date Needed By: ____/____/____ Time: ____:____		____ Clot ____ Other: _____	
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 and SHIP
HLA Low Resolution (A, B, C, AB, ABC, DRB1, DRB3 B4 B5, DQB1/DQA1, DPB1), HLA-A29, HLA-B27, HLA-B51, HLA-Narcolepsy, HLA-Celiac, HLA-DR Single Antigen	5 - 14 ml EDTA whole blood (lavender top) or ACDA whole blood (yellow top) or 4 buccal swabs	Room temperature
HLA High Resolution (A, B, C, DRB1, DQB1, DPB1), HLA-A*02:01, HLA-B*15:02, HLA-B*57:01	5 - 14 ml EDTA whole blood (lavender top) or ACDA whole blood (yellow top) or 4 buccal swabs	Room temperature
HLA Antibody Detection, HLA Antibody Identification	10 ml Clotted (red top) blood	Room temperature
Platelet Recipient: HLA-AB Low Resolution HLA Antibody Identification Class I High Resolution * Indicate STAT Testing, if required	14 ml EDTA whole blood (lavender top) or 4 buccal swabs and 10 ml Clotted (red top) blood	Room temperature
Kidney, Heart, Liver, Pancreas, Lung Recipient - Initial Workup	REFER TO HISTOCOMPATIBILITY LAB TRANSPLANT TESTING REQUISITION	Room temperature
Kidney Donor Workup	REFER TO HISTOCOMPATIBILITY LAB TRANSPLANT TESTING REQUISITION	Room temperature
Crossmatch (Flow Cytometric)	REFER TO HISTOCOMPATIBILITY LAB TRANSPLANT TESTING REQUISITION	Room temperature
Bone Marrow (Stem Cell) recipients or donors	REFER TO HISTOCOMPATIBILITY LAB TRANSPLANT TESTING REQUISITION	Room temperature

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**