



**Regional Histocompatibility Lab
Requisition for External Testing**

*UHN-HLA Laboratory
200 Elizabeth Street, 11E-444
Toronto, Ontario M5G 2C4
416.340.4995 Fax 416.340.3133
Samples are accepted Monday to Friday 9 am-5pm*

Patient Name/Donor Name/GRID:

MRN:

DOB:

Sex:

Patient Information

Draw Date:

Draw Time:

Draw ID:

Requesting Centre: _____

RECIPIENT HLA TESTING:

- Initial HLA Typing (High resolution all loci) 10 ml blood ACD tube\Buccal Swab.
- Confirmatory HLA Typing (Int. Resolution HLA-A, B, DRB1) 10 ml blood ACD tube\Buccal Swab.
- PRA (anti HLA antibodies) – 10 ml blood, red top tube (no anticoagulant)

Diagnosis _____

RELATED DONOR HLA TYPING:

Note: Donor testing requires a written request from the patient's transplant center.

Choose one option below.

- Initial HLA Typing (High Resolution all loci) 10 ml blood ACD tube\Buccal Swab.
- Confirmatory HLA Typing (Int. Resolution HLA-A, B, DRB1) 10 ml blood ACD tube\Buccal Swab.
- Sample for storage only at this time.

Recipient Name: _____ **MRN:** _____ **DOB:** _____ **Sex:** _____

Relationship of the Donor to the Recipient: _____

UNRELATED DONOR HLA TESTING:

Note: Donor testing requires a written request from the patient's transplant center.

- Initial HLA Typing (High resolution all loci) 10 ml blood ACD tube\Buccal Swab.
- Confirmatory HLA Typing (Int. Resolution HLA-A, B, DRB1) 10 ml blood ACD tube\Buccal Swab.

Recipient Name: _____ **MRN:** _____ **DOB:** _____ **Sex:** _____

Lab Acc. # _____

Ordering Physician: _____