REQUISTION FOR EXTERNAL BMT TESTING

UHN Canada's Hospital

Regional Histocompatibility Lab
Requisition for External BMT 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: _____
Transplant Center (HSC or PMH) : _____

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: _____
If NOT from a UHN affiliated or partner hospital, provide name of the requesting Transplant Center and attach referral letter/form.

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:**_____

Report to be emailed or faxed to: _____ **Invoice to be sent to:**