## REQUISITION FOR EXTERNAL TESTING

### 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

<table>
<thead>
<tr>
<th>Patient Name/Donor Name/GRID:</th>
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<tbody>
<tr>
<td>MRN:</td>
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<tr>
<td>DOB:</td>
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<td>Sex:</td>
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### 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: ____________________________**

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