STANFORD BLOOD CENTER

HLA TRANSPLANT TESTING ORDER FORM

Turnaround time requested: ◯ STAT ◯ Routine

Thank you for your interest in HLA transplant testing services with Stanford Blood Center.

Please complete the following order form, **print a copy and send it with your sample(s) to:**

Stanford Blood Center — HLA Lab
3373 Hillview Avenue
Palo Alto, CA 94304

Phone: (650) 724-6742 | FAX: (650) 723-6350 | Order online: stanfordbloodcenter.org/hla

Draw date (mm/dd/yyyy) _____ **Draw time (XX:XX a.m./p.m.)** _____

Phlebotomist initials _____

Patient Information

Patient type: ◯ Recipient ◯ Donor

Last name _____ First name _____ Middle name _____

Medical record number _____ Date of birth (DOB) _____ ABO _____

Street address _____ Address line 2 _____ Phone _____

City _____ State _____ Zip code _____

Sex at birth (check one): ◯ Male ◯ Female

Ethnicity:

- ◯ Asian
- ◯ Black or African American
- ◯ Caucasian
- ◯ Hispanic
- ◯ Middle Eastern
- ◯ Mixed Race
- ◯ Native American
- ◯ Pacific Islander
- ◯ Other (decline to state)
- ◯ Unknown

If patient is a donor:

Recipient name: _____ Recipient MRN: _____

Relationship to recipient: _____ Recipient DOB: _____

Sensitizing Event/Treatment History (Recipient Only)

Number of Pregnancies _____ Transplant(s): **Date** _____ IVIG: **Date** _____ VAD: **Date** _____

Transfusion(s): **Date** _____ Donor ID: _____ ATG: **Date** _____ Rituximab: **Date** _____

Other _____

Ordering Physician / Lab

NOTE: SBC bills the physician/physician's facility. SBC does not bill patients or patients' insurance providers.

Requesting entity: _____

Ordering physician first name _____ Ordering physician last name _____

Clinic/lab address _____ Address line 2 _____

City _____ State _____ Zip code _____

Department _____ Diagnosis/ICD-10** _____ UPIN#/NPI# _____

Ordering physician phone _____ Ordering physician email _____

Send results to:

* Attn (name) _____ * FAX or email _____

Secondary attn (name) _____ Secondary FAX or email _____

** REQUIRED*

*** ICD-10 Diagnostic Insurance Code is optional for Kaiser patients; required for all other patients.*

Test Ordering

Transplant Category: (select all that apply)

- ☐ Bone marrow
- ☐ Heart
- ☐ Kidney
- ☐ Liver
- ☐ Pancreas
- ☐ Lung
- ☐ Intestine

HLA Typing

Packages (All Loci)

- ☐ Low resolution (RTPCR)
- ☐ Intermediate resolution (SSO)
- ☐ High resolution (NGS)

OR, Individual Inermediate Resolution Loci (choose all that apply):

- ☐ HLA-A
- ☐ HLA-B
- ☐ HLA-C
- ☐ HLA-DRB3/4/5
- ☐ HLA-DPA1
- ☐ HLA-DPB1
- ☐ HLA-DQA1
- ☐ HLA-DQB1
- ☐ HLA-DRB1

Antibody Testing

Pre-transplant

- ☐ IgG antibody screening
- ☐ C1Q antibody screening
- ☐ Desensitization Ab monitoring (IgG & C1Q)
- ☐ Platelet compatibility Ab screening
- ☐ IVIG inhibition assay

Post-transplant

- ☐ IgG DSA screening
- ☐ C1Q DSA screening

Other Testing

- ☐ T & B cell flow crossmatch
- ☐ Chimerism
  - * Specify subset(s): _____
  - Has the patient ever been tested for chimerism? ◯ Yes ◯ No
- ☐ Kit for send-out
- ☐ KIR typing

Additional comments/considerations: _____

Specimen Source:

- ◯ Peripheral blood
- ◯ Bone marrow
- ◯ Pre-extracted DNA
- ◯ Buccal swab
- ◯ Pre-aliquoted serum
- ◯ Other: _____

NOTE: If submitting buccal swab or whole blood, processing and storage charges may apply.

If IVIG (choose one):

- ☐ Pre-transplant
- ☐ Post-transplant

Collection Tube:

- ☐ Yellow top (ACD sol A)***
- ☐ Red top (No anti-coagulant)****

***Required for Typing and Crossmatch — Adult: 6 tubes / Pedi: 1 tube, 3 mL
**** Required for Antibody, DSA and Crossmatch — Adult: 1 tube / Pedi: 1 tube, 3 mL