MIDWEST TRANSPLANT NETWORK

LABORATORY REQUISITION FORM
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Laboratory Director:
Taba Kheradmand, PhD, D(ABHI)

LAB CONTROL LABELS-AFFIX TO SPECIMEN.
PATIENT NAME MUST BE WRITTEN ON THE LABEL

CLIENT: Children's Mercy Hospital Lab
2401 Gillham Road
Kansas City, MO 64108

Items to be completed by Patient/Donor:
- Race
- Sex
- Date & Time of Draw
- Recipient Relationship and/or Recipient Name

Patient Name: (LAST) _____ (FIRST): _____ (MI): ____ SS#: _____ DOB: _____ Race: _____ Sex: ____

Diagnosis: _____ Requesting Physician: _____ Transplant Center: _____ Coordinator: _____

Organ Transplant Category:
☐ Kidney ☐ Lung
☐ Heart ☐ Pancreas
☐ Liver ☐ Bone Marrow
☐ Other_____

NEW SENSITIZING EVENTS:
☐ Transplant (#) _____
☐ Pregnancy (#) _____
☐ Transfusions (#Units) _____ (Date) _____ _____
☐ Other (Vaccine/Infection within 3 months) _____

If Family Member/Potential Donor; Relationship: _____ Recipient Name: _____ Date & Time Drawn: _____

Blood to Be Drawn at MTN: Date: _____ Time of Arrival: _____

SOLID ORGAN Test Profile

☐ **Initial Recipient Workup** (HLA Typing, Antibody Screen, Class I/II Single Antigen ID)
☐ **Initial Living Donor Workup** (HLA Typing, Flow Crossmatch T & B Cell)
☐ **Monthly Antibody Screen**** ☐ Sample to be Screened Prior to UNOS Re/Activation
☐ **Final Living Donor Workup (Transplant Date** _____) (Final Crossmatch, Recipient Antibody Screen)
☐ **Donor-Specific Antibody (DSA)** (Class I/II Single Antigen ID)

Priority ☐ STAT*

HEMATOPOIETIC STEM CELL TRANSPLANT Test Profile

☐ **Bone Marrow Recipient Work Up** (HLA Typing Class I/II) ☐ Verification Typing
☐ **Bone Marrow Donor Work Up** (HLA Typing Class I/II) ☐ Verification Typing
☐ **Antibody Screen** (Class I/II Single Antigen ID)
☐ **Molecular Engraftment Analysis (STR)** Transplant Date: _____ Donor Name: _____
☐ **Peripheral Blood** ☐ **Bone Marrow** ☐ **Buccal Swab**
☐ Myeloid ☐ Lymphoid

Priority ☐ STAT*

INDIVIDUAL TESTS

Blood Typing
☐ ABO Typing
☐ Anti-A IgG Titer
☐ STAT*

HLA Typing
☐ A/B/C (High Res)
☐ DRB (High Res)
☐ DQA1/DQB1 (High Res)
☐ DPA1/DPB1 (High Res)
☐ STAT*

Flow Crossmatch (T & B Cell)
☐ Allogeneic
☐ Autologous
☐ STAT*

Antibody Screen
☐ Class I/II MIX Screen (+/-)
☐ Class I Single Antigen ID
☐ Class II Single Antigen ID
☐ C1q Single Antigen ID
☐ STAT*

Infectious Disease
☐ Donor Panel
☐ EBV
☐ Toxo
☐ WNV - NAT
☐ RPR Titer
☐ STAT*

TEST	SPECIMEN REQUIREMENTS	NOTE
HLA Typing	One 5 ml EDTA Tube (Lavender Top)	
ABO Typing	One 10 ml Clot Tube (Red Top)	Confirmation ABO requires separate draw times on 2 pre-transfused samples
Antibody Screen/DSA	One 10 ml Clot Tube (Red Top)	Please draw prior to dialysis to prevent heparin contamination
Flow Crossmatch	**RECIPIENT:** One 10 ml Clot Tube (Red top) **POTENTIAL DONOR**: One 5 ml EDTA (Lavender Top); Three 10 ml Acid Citrate Dextrose Tubes (Yellow Top)	
Engraftment Analysis	**PERIPHERAL BLOOD**: One 5 or 10 ml EDTA (Lavender Top) **BONE MARROW:** The specimen should be drawn without anticoagulant, then transferred to a 5 ml EDTA Tube (Lavender Top)	**Bone Marrow: Call for immediate pick up.** Refrigerate specimens that will not be delivered the same day.

Key: *STAT fee will apply, ** For Monthly Antibody Algorithm see Laboratory Agreement
When ordering tests for which Medicare reimbursement will be sought, authorized testing individuals should only order tests that are medically necessary for the diagnosis or treatment of a patient rather than for screening purposes.