Cleveland Clinic Laboratories

2119 E. 93rd / L15
Cleveland, OH 44106
216.444.5755 or 800.628.6816

HISTOCOMPATIBILITY & IMMUNOGENETICS TEST REQUISITION

Allogen Laboratories

<<FORM_ID>>

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)

Last Name | First | MI

Address | Birth Date (MM/DD/YYYY) | Sex ☐ M ☐ F

City

State | Zip | Home Phone

Hospital/Physician Office Patient ID # | Accession #

CLIENT INFORMATION

PATIENT INFORMATION HISTORY

(PLEASE ATTACH DETAILED INFORMATION WHERE INDICATED INCLUDING DONOR, LOCATION AND DATE)

PATIENT TYPE: ☐ Recipient ☐ Donor **ABO BLOOD TYPE:** ☐ A ☐ B ☐ O ☐ AB

TRANSPLANT TYPE: ☐ Kidney ☐ Pancreas ☐ Heart ☐ Lung ☐ Liver ☐ Bone Marrow ☐ Intestine

☐ Other (specify): _____

TRANSPLANTED PREVIOUSLY: ☐ No ☐ Yes (attach details): _____

PREGNANCIES #: _____ **TRANSFUSIONS #:** _____ Date of last transfusion: _____

PREVIOUS NEPHRECTOMY? ☐ No ☐ Yes (attach details): _____

PREVIOUS LVAD? ☐ No ☐ Yes (attach details): _____

DRUG THERAPY: ☐ Rituximab ☐ Campath ☐ IVIG ☐ Thymoglobulin ☐ Other (specify): _____

SPECIMEN INFORMATION

Sample Type: ☐ Blood ☐ Other (specify): _____

Collection Date (MM/DD/YYYY): _____/_____/_____

Collection Time: _____ ☐ A.M. ☐ P.M.

Collected By (NAME): _____

Call Results To (NAME/PHONE #): _____

IF ENCLOSED SAMPLE IS FROM A DONOR

Please attach HLA typing of donor

Recipient's Name: _____

Recipient's DOB (MM/DD/YYYY): _____/_____/_____

Relationship of Donor to Recipient: _____

DIAGNOSIS CODE (REQUIRED) ICD-10 Codes 1. _____ 2. _____ 3. _____

ADDITIONAL NOTES/COMMENTS:

SPECIMEN COLLECTION & TRANSPORT INFORMATION

INITIAL WORKUP, **SOLID ORGAN** RECIPIENT/DONOR:
(3) 6 mL whole blood (red top) + (1) 4mL whole blood (EDTA purple top)

INITIAL WORKUP, **BONE MARROW** RECIPIENT/DONOR:
(1) 4mL whole blood (EDTA purple top)

ENGRAFTMENT / CHIMERISM:
(1) 10 mL whole blood (ACD yellow top, solution A)

CROSSMATCH:
PATIENT: (1) 6 mL whole blood (red top), and
DONOR: (4) 10 mL whole blood (Green Sodium Heparin Tubes)

ANTIBODY TESTING:
(3) 6 mL whole blood (red top)

OTHER:
Contact Allogen Laboratories

DIRECTIONS:

DO NOT REFRIGERATE BLOOD.
Send samples immediately after drawing to be received by Allogen Laboratories within 24 hours of collection.

SEND SPECIMENS TO:

Cleveland Clinic
Allogen Laboratories / C100
10524 Euclid Ave
Cleveland, OH 44106

CONTACT:

Allogen Laboratories
P: 216.444.6582
F: 216.444.8261
coordinator@ccf.org

SELECT TESTS TO BE PERFORMED:

INITIAL WORKUP
☐ Recipient
☐ Donor

CROSSMATCH
☐ Recipient/Donor Crossmatch
☐ Autologous Crossmatch

VERIFY HLA
☐ Verify HLA

ENGRAFTMENT/CHIMERISM
☐ Pre-TX Genotyping (Bone Marrow Recipient/Donor)
☐ Post-TX Chimerism (Bone Marrow Recipient)
☐ GVHD Testing (Solid Organ Recipient)

ANTIBODY TESTING
☐ Pre-TX Antibody Screen
☐ Post-TX / Reflex Antibody Screen
☐ Non-HLA Autoantibody Screen
☐ AT1R Antibody Screen

ADDITIONAL TESTING
☐ Kit Request
☐ Other: please specify in Comments box

*CPT codes available online at clevelandcliniclabs.com 1/2023

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