City of Hope LABORATORIES

Histocompatibility Laboratory Request Form

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This form must accompany **each** specimen.

This sample is for a ❑ Patient or a ❑ Donor (please check one).
If a donor, please provide the name of the patient here: ______________________________

Last Name	First Name	Sex	Date of Birth (mm/dd/yyyy)	Race
Street Address		City	State/Province/Territory	Zip/Postal Code
Medical Record Number	Specimen # (if available)		Date and Time Collected	

Referring Physician/Laboratory Information

Please Note: City of Hope Histocompatibility Laboratory is a reference lab and does not bill third parties. The referring physician/laboratory is liable for all charges.

Physician First/Last Name *(Required)*	NPI # (Required)
Physician Facility/Institution	Phone Number
Street Address	Contact Person Name
City	Contact Person Signature/Date
State/Province/Territory | Zip/Postal Code	Please select a way to receive test results ❑ FAX Number: ______________________ ❑ EMAIL: ______________________
Physician Signature	

HLA Testing

Low Res Molecular Typing		High Res Molecular Typing		
Class I	Class II	Class I	Class II	
❑ A	❑ DQB1	❑ A	❑ DQB1	❑ DRB3
❑ B	❑ DRB1	❑ B	❑ DPB1	❑ DRB4
❑ C		❑ C	❑ DRB1	❑ DRB5

Engraftment (Chimerism) Analysis Cell subset analysis available. *TRANSPLANT DATE* ________________

SAMPLE TYPE: ❑ Pre-Transplant Patient ❑ Donor DONOR ID: ______________________

❑ PB (Peripheral Blood)	❑ CD4 (T Helper)	❑ CD15 (Granulocytes)
❑ BM (Bone Marrow)	❑ CD8 (T Cytotoxic)	❑ CD19 (B Cells)
❑ BMCD3 (BM Subset)	❑ CD14 (Monocytes)	❑ CD 56 (NK Cells)
❑ CD3 (Total T Cells)		

Other Tests

❑ Leukocyte Antibody Screen	❑ KIR (Killer cell Immunoglobulin-like Receptors)	❑ Leukocyte Crossmatch (includes patient's Antibody Screen)
❑ Vaccine-Related Typing	❑ CCR5 DEL32 Mutation	Donor ID *(Required)*______________