

CALGARY HISTOCOMPATIBILITY AND IMMUNOGENETICS (HIL) REQUISITION

Alberta Health Care card AND one other form on government issued identification **MUST** be presented at each visit



Histocompatibility and Immunogenetics Diagnostic and Scientific Centre

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Scanning Label or Accession # (lab only)

Patient	PHN		Date of Birth (dd-Mon-yyyy)		Scanning Label or Accession # (lab only)	
	Expiry: _____					
	Legal Last Name		Legal First Name		Alternate Identifier	
	Middle Name		Preferred Name		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X Non-binary/Prefer not to disclose	
Address		City/Town		Prov		Postal Code
Provider(s)	Authorizing Provider Name (last, first, middle)			Copy to Name (last, first, middle)		Copy to Name (last, first, middle)
	Address		Phone		Address	
	CC Provider ID	CC Submitter ID	Legacy ID		Phone	
	Clinic ID			Clinic ID		Clinic ID
Collection	Date (dd-Mon-yyyy)		Time (24 hr)		Location	
Collector ID						

PATIENT INFORMATION & TEST REQUISITION MUST BE COMPLETED TO ENSURE ACCURATE TESTING & INTERPRETATION

HEMATOPOIETIC STEM CELL TRANSPLANT

RECIPIENT:

Specimen Requirements

Diagnosis: _____

Transfusions: ☐ NO ☐ YES Date: _____

NOTE: For all Antibody Screening—If drug therapy given, indicate drug:

☐ Thymoglobulin (ATG) ☐ Alemtuzumab ☐ Rituximab ☐ IVIG ☐ Other: _____

- | | | | |
|--|--|--|-----------------------|
| <input type="checkbox"/> HLABMTPTHR | Bone Marrow Recipient Typing – High Resolution | <input type="checkbox"/> Retyping | 2 x 8.5 mL ACD-A tube |
| Connect Care Name: Bone Marrow Recipient – High Res HLA Typing [LAB6050] | | | |
| <input type="checkbox"/> HLABMTPT | Bone Marrow Recipient Typing | | 4 x buccal swabs |
| Connect Care Name: Bone Marrow Recipient Typing – Buccal Swab [LAB6049] | | | |
| <input type="checkbox"/> HLABMTPTVT | Bone Marrow Recipient Typing – Verification | | 2 x 8.5 mL ACD-A tube |
| Connect Care Name: Bone Marrow Recipient Verification HLA Typing [LAB6055] | | | |
| <input type="checkbox"/> HLAPLTAB | Screen for HLA Platelet Antibodies | | 2 x 4 mL red top tube |
| Connect Care Name: HSCT – HLA Antibody Investigation [LAB6067] | | | |
| <input type="checkbox"/> HLAPLTABT | HLA Typing for Positive Platelet Antibody Screens | | 2 x 8.5 mL ACD-A tube |
| Connect Care Name: Not Applicable | | | |

DONOR:

Specimen Requirements

Intended Recipient:	Name	_____
	PHN/MRN	_____

- | | | | |
|---|--|---|-----------------------|
| <input type="checkbox"/> HLABMTSIB | Bone Marrow Donor Typing – Sibling | <input type="checkbox"/> Recipient Out of Province | 2 x 8.5 mL ACD-A tube |
| Connect Care Name: Bone Marrow Donor HLA Typing – Sibling [LAB6053] | | | |
| <input type="checkbox"/> HLABMTNONSIB | Bone Marrow Donor Typing – Non-Sibling | Relationship: _____ | 2 x 8.5 mL ACD-A tube |
| Connect Care Name: Bone Marrow Donor HLA Typing – Non-Sibling [LAB6054] | | | |
| <input type="checkbox"/> HLABMTDVT | Bone Marrow Donor Typing – Verification | | 2 x 8.5 mL ACD-A tube |
| Connect Care Name: Bone Marrow Donor Verification HLA Typing [LAB6056] | | | |
| <input type="checkbox"/> HLABMTMUD | Bone Marrow Donor Typing – Unrelated | | 2 x 8.5 mL ACD-A tube |
| Connect Care Name: Bone Marrow HLA Typing – Unrelated [LAB6052] | | | |