



TRANSPLANT LAB - University Hospital
339 Windermere Road, London, Ontario N6A 5A5 • Telephone (519) 663-3320

**TRANSPLANTATION IMMUNOLOGY
INCLUDING HLA ANTIGENS**

**NOTE: Testing cannot proceed unless all of Section A is completed.
See back page for Sample Requirements**

SECTION A

TEST ORDERED BY: _____ COLLECTION DATE (YYYY/MM/DD): _____

SEND REPORT TO: _____ SAMPLE COLLECTED BY: _____

REASON FOR TEST: Transplant (Donor Recipient) (Solid Organ Marrow / HSC)
 Transfusion Disease Association Other Not Provided

PATIENT LOCATION: LHSC IV LHSC OP LHSC IP Reference Centre Dialysis (Site: _____) Other

REQUESTED TEST:

HLA ABC Antigens (Class I) Anti-HLA Antibody Screen - Routine Crossmatch (pre-book by calling 663-3320)
 HLA DR/DQ Antigens (Class II) Anti-HLA Antibody Screen - "Quick Screen" Other: _____

SPECIMEN SOURCE: Whole Blood Serum Spleen Other: _____

DO NOT WRITE BELOW THIS LINE - DO NOT WRITE BELOW THIS LINE - DO NOT WRITE BELOW THIS LINE - DO NOT WRITE BELOW THIS LINE

TESTING DATE (YYYY/MM/DD): _____ ID #: _____

HLA CLASS I TYPING by Serology DNA Analysis (PCR-SSP) Other: _____

HLA-A _____, B _____, Cw _____, Other: _____

HLA CLASS II TYPING by DNA Analysis (PCR-SSP) Other: _____ HLA CLASS II TYPING TO FOLLOW

DRBI* _____, DQBI* _____, Other: _____

Serological Equivalent: DR _____ DQ _____ Other: _____

CROSSMATCH PATIENT SERA

DONOR NAME:							
DONOR CELL TYPE:							
DONOR CELL TYPE:							

T CELL CROSSMATCH PERFORMED BY: Dye Exclusion with AHG Flow Cytometry Other: _____

B CELL CROSSMATCH PERFORMED BY: Dye Exclusion Flow Cytometry Other: _____

LYMPHOCYTE ANTIBODY SCREEN

TECHNIQUE

		DYE EXCLUSION WITH AHG	DYE EXCLUSION	OTHER
T CELL CYTOTOXICITY _____ %	PANEL SIZE: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B CELL CYTOTOXICITY _____ %	PANEL SIZE: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T CELL QUICK SCREEN _____ %	PANEL SIZE: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS

REPORT RELEASE DATE (YYYY/MM/DD): _____

SIGNATURE

HLA ABC Antigens* (Class I) _____ 20 mL Heparinized Blood (green tops)

HLA DR/DQ Antigens (Class II) _____ 10 mL EDTA Blood (mauve tops)

Anti-HLA Antibody Screen (routine or quick screen) _____ 7 mL Clotted (red top)

CROSSMATCHING

1) DONOR _____ { 100 mL Heparinized (green tops)
5 mL EDTA (mauve tops)

2) RECIPIENT _____ 7 mL Clotted (red top)

* Potential bone marrow/HSC transplant recipients or HLA-matched platelet recipients should have 10 mL of EDTA blood drawn instead of the Heparinized blood for this test.

*Complete shipping and storage requirements are available by contacting
the Transplant Laboratory @ (519) 663-3320*