Date }

BARNES JEWISH Hospital

Non-Renal Transplant and Disease Association

HLA Laboratory, Department of Laboratories, Barnes-Jewish Hospital, St. Louis, Missouri 63110
Phone: (314) 362-5323 Fax: (314) 362-4647 http://pathology.wustl.edu/patientcare/hlalab.php

ACCOUNT INFORMATION

NAME

ADDRESS

CITY STATE ZIP

PHONE

ORDERING PHYSICIAN

BILL TO: ☐ ACCOUNT ☐ PATIENT/INSURANCE ☐ ALTERNATE

SEND ADDITIONAL COPY OF REPORT TO:

CLIENT NUMBER/PHYSICIAN NAME PHONE/FAX NUM.

PHYSICIAN'S ADDRESS CITY, STATE, ZIP

COLLECTION TIME : ☐ AM ☐ PM

COLLECTION DATE MO DAY YR

☐ **STAT** CALL RESULTS TO: (#) COMPLETE AND ATTACH STAT FLYER

BJH REGISTRATION #

REGISTERED BY }

PATIENT

PATIENT'S NAME (LAST) (FIRST) (MI) SEX DATE OF BIRTH MO DAY YR PATIENT'S SS #

PATIENT'S ADDRESS CITY STATE ZIP PHONE

REFERENCE # RACE DIAGNOSIS

RESP. PARTY

PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY ☐ 1-SELF ☐ 2-SPOUSE ☐ 3-CHILD ☐ 4-OTHER

NAME OF RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT) INSURED SS# (IF NOT PATIENT)

ADDRESS OF RESPONSIBLE PARTY APT # DATE OF BIRTH MO DAY YR

CITY STATE ZIP

INSURANCE

MEDICAID # STATE MEDICARE # (INCLUDE PREFIX/SUFFIX) ☐ PRIMARY ☐ SECONDARY MEDICARE RETIREMENT OR DISABILITY DATE:

INSURANCE COMPANY NAME PLAN CARRIER CODE

SUBSCRIBER / MEMBER # LOCATION GROUP #

INSURANCE ADDRESS PHYSICIAN'S PROVIDER #

CITY STATE ZIP

EMPLOYER'S NAME OR NUMBER WORKER'S COMP ☐ YES ☐ NO

TRANSPLANT DEMOGRAPHICS

This is a

☐ **patient**

☐ **donor, for** ____________________

(please print patient's name)

Relationship to patient: ____________________

Transplant type: ☐ BMT ☐ Heart ☐ Lung ☐ Liver Other: __________

Timing: ☐ Pre-transplant ☐ Post-transplant

For transfusion support: ☐ Platelet refractoriness ☐ TRALI work-up

Please page the transfusion service for any question: 314-747-1320, option 1.

Transplant patient sensitization history:

Blood transfusions ☐ YES ☐ NO

Previous transplantation ☐ YES ☐ NO

Pregnancies ☐ YES #_____ ☐ NO

History of autoimmune disease ☐ YES ☐ NO

History of therapeutic antibodies that may interfere with crossmatch:

☐ Rituximab ☐ Tocilizumab ☐ Daclizumab

☐ Alemtuzumab ☐ Thymoglobulin

Other:

	TEST NAME (TRANSPLANT)	TUBE TYPE
	Class I DNA Typing (A/B/C)	1 Pink Tube or 1 Large Lavender Tube (EDTA)
	Class II DNA Typing (DR/DQ/DP)	1 Pink Tube or 1 Large Lavender Tube (EDTA)
	HLA antibody screen by PRA	1 Full Red/Gray Tube
	KIR DNA Typing	1 Pink Tube or 1 Large Lavender Tube (EDTA)
	HLA antibody screen by single-antigen	1 Full Red/Gray Tube
	Preliminary crossmatch, donor	3 Full ACD tubes **from the donor**
	Final crossmatch, donor	5 Full ACD tubes **from the donor**
	Final crossmatch, recipient	1 Full Red/Gray Tube – 3 Full ACD tubes **from the patient**
	Extra Tubes	#_____ Color ____________________
	TEST NAME (DISEASE ASSOCIATION)	**TUBE TYPE**
	HLA-A*29 for uveitis and birdshot retinopathy	1 Pink Tube or 1 Large Lavender Tube (EDTA)
	HLA-B*27 for ankylosing spondylitis	1 Pink Tube or 1 Large Lavender Tube (EDTA)
	HLA-B*51 for Behcet's disease	1 Pink Tube or 1 Large Lavender Tube (EDTA)
	HLA-B*57:01 for abacavir hypersensitivity	1 Pink Tube or 1 Large Lavender Tube (EDTA)
	HLA-B*58:01 for allopurinol hypersensitivity	1 Pink Tube or 1 Large Lavender Tube (EDTA)
	HLA-B*15:02 for carbamazepine hypersensitivity	1 Pink Tube or 1 Large Lavender Tube (EDTA)
	HLA-DQ2/DQ8 for celiac disease	1 Pink Tube or 1 Large Lavender Tube (EDTA)
	HLA-DQB1*06:02 for narcolepsy	1 Pink Tube or 1 Large Lavender Tube (EDTA)
	HLA typing for cancer vaccine. Please specify locus: __________	1 Pink Tube or 1 Large Lavender Tube (EDTA)
	Other. Please specify allele/disease: __________	1 Pink Tube or 1 Large Lavender Tube (EDTA)

For questions please visit http://pathology.wustl.edu/patientcare/hlalab.php or call HLA lab at (314)362-5323

BJ 4-1195-1277 (05/31/16)