

**Section 1: Patient Details**

	<i>Recipient Information</i>	<i>Donor Information</i>
Name		
Unique ID (MRN/Lab ID)		
Date of Birth		
Age		
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Blood Group		
Contact No.		
Relationship to Recipient	N/A	

**Section 2: Photographic Identification & Attestation**

<i>Recipient Photo</i>	<i>Donor Photo</i>
<p>[Affix Recipient Photo Here]</p> 	<p>[Affix Donor Photo Here]</p> 
Attested by Transplant Physician (Signature/Date):	Attested by Transplant Physician (Signature/Date):

**Section 3: Clinical History (Sensitizing Events & Key Details)**

<i>Detail</i>	<i>Information</i>
Primary Diagnosis/Reason	
Transplant Type	<input type="checkbox"/> Kidney <input type="checkbox"/> Heart <input type="checkbox"/> Lung <input type="checkbox"/> Liver <input type="checkbox"/> Pancreas <input type="checkbox"/> Bone Marrow <input type="checkbox"/> Other: _____
Previous Transplants?	<input type="checkbox"/> No <input type="checkbox"/> Yes (Type/Date): _____
Previous Transfusions?	<input type="checkbox"/> No <input type="checkbox"/> Yes (Approx. Date(s)): _____
Pregnancies including abortions?	<input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes (Number): _____
Known HLA Antibodies / %PRA?	<input type="checkbox"/> No <input type="checkbox"/> Yes (Specify Class/Specificity/%): _____
Therapy details of interferences	Specify: _____ Last Dialysis Date/Time

**Section 4: Phlebotomist Declaration**

"I hereby declare that I have correctly identified the Recipient and Donor (if applicable) named on this form using their hospital identification and/or photographic identification provided, prior to sample collection. I confirm that the details on the sample labels correspond accurately to the identified individuals and the information provided on this requisition form."

Phlebotomist Name: \_\_\_\_\_

Phlebotomist Signature: \_\_\_\_\_

ID (if applicable): \_\_\_\_\_

Date & Time of Collection: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ : \_\_\_\_

**Section 5: Test(s) Requested**

Category	Test Description	Select (✓)
HLA Genotyping	Comprehensive High-Resolution Typing (A, B, C, DRB1, DRB3/4/5, DQA1, DQB1, DPA1, DPB1)	<input type="checkbox"/>
	Low-Resolution Typing (A, B, DRB1, DQA1, DQB1)	<input type="checkbox"/>
Histocompatibility (Crossmatch)	CDC Crossmatch (T and B cells)	<input type="checkbox"/>
	Flow Cytometry (FC-XM) Crossmatch (T and B cells)	<input type="checkbox"/>
HLA Antibody Testing (Luminex)	HLA Class I & II Antibody Screen (Luminex)	<input type="checkbox"/>
	Single Antigen Bead Class I (Luminex)	<input type="checkbox"/>
	Single Antigen Bead Class II (Luminex)	<input type="checkbox"/>
	Single Antigen Bead Class I & II (Luminex)	<input type="checkbox"/>
Immunological Workup	Virtual Crossmatch (VXM) (Requires prior HLA testing at CMDL)	<input type="checkbox"/>
	Immunological Workup (HLA) (Requires prior testing at CMDL)	<input type="checkbox"/>
Post-Transplant Monitoring	Specify: <input type="checkbox"/> Viral <input type="checkbox"/> Non-HLA Ab ID <input type="checkbox"/> Chimerism <input type="checkbox"/> dd-cfDNA	-
Other (Specify)		

**Section 6: Sample Requirements & Collection Information**

- Recipient Sample Type(s) Collected:  Whole Blood (EDTA)  Serum  Other: \_\_\_\_\_
- Recipient Sample ID(s): \_\_\_\_\_
- Donor Sample Type(s) Collected:  Whole Blood (EDTA)  Serum  Other: \_\_\_\_\_
- Donor Sample ID(s): \_\_\_\_\_

**Sample Tube Details:**

Test Parameters	Recipient Sample (# Tubes / Color / Type / Vol.)	Donor Sample (# Tubes / Color / Type / Vol.)
CDCXM & FCXM	1 / Red / Plain / 4 mL	1 / Yellow / ACD-A / 9 mL
Antibody Screening	1 / Purple / K2-EDTA / 2 mL	N/A
SAB Class I & II	1 / Purple / K2-EDTA / 2 mL	N/A
HLA Typing (Luminex/NGS)	2 / Purple / K2-EDTA / 2 mL	2 / Purple / K2-EDTA or ACD-A / 2 mL

**Section 7: Transport Details**

- Primary Method: Transport samples to the laboratory immediately at ambient/room temperature after collection. Aim for receipt within 24 hours.
- Alternative (if immediate transport is not possible): Samples may be stored temporarily at refrigerated temperatures (4°C to 8°C) prior to dispatch. Ensure they are packaged to maintain this temperature during transit if required by local protocols.
- Crucial: DO NOT FREEZE blood or tissue samples intended for HLA testing or crossmatching, as freezing damages the cells.
- Guidelines: All sample handling, storage, and transport should follow the best practices outlined in the current American Society for Histocompatibility and Immunogenetics (ASHI) Standards.
- Shipping Regulations: If shipping externally, ensure packaging complies with relevant regulations for biological substances.

**Section 8: Requesting Clinician Information**

Detail	Information
Clinician Name & Specialty	Dr. _____ Specialty: _____
Hospital/Clinic Name & Address	_____
Clinician Contact (Phone/Email)	Ph: _____ Email: _____
Signature & Date of Request	Sig: _____ Date: ____ / ____ / ____

**Section 9: Consent**

(Signature confirms consent for sample collection and requested tests)

Role	Signature	Date
Recipient / Guardian	_____	____ / ____ / ____
Donor / Guardian	_____	____ / ____ / ____