HISTOCOMPATIBILITY REQUISITION

MLabs
Expertise Delivered Personally

Michigan Medicine – University of Michigan
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Client
REFR

Ward
REFR

Patient Reg or MRN:

Patient Name: Last First MI

Birthdate: Gender: ○M ○F

Ordering Doctor: Last First NPI#

Patient Address City State ZIP Home Phone #

Policy Holders Name | Primary Insurance (Card Name) | Primary Policy/Contract # | Primary Group # | Policy Holders DOB

Policy Holders Name | Secondary Insurance (Card Name) | Secondary Policy/Contract # | Secondary Group # | Policy Holders DOB

Bill To: ☐ Client/Referring Institution ☐ Patient/Insurance

☐ Medicare = ☐ In Patient on DOS ☐ Out Patient on DOS ☐ Non Patient on DOS

If patient or insurance information is not included or attached to this form, your facility will be billed. For Medicare patients classified as a hospital inpatient or outpatient on the date of service, charges must be billed to the referring client.

ICD-10 CODES

ICD-10 Codes are required for billing. When ordering tests for which reimbursement will be sought, order only tests that are medically necessary for the diagnosis and treatment of the patient.

REFERRING PHYSICIAN TO BE CONTACTED WITH RESULTS AND/OR QUESTIONS

Referring Physician Referring Institution Phone Fax

Address City State ZIP Country

This request to order tests from MLabs certifies to MLabs that (1) the ordering physician has obtained written informed consent from the patient as required by applicable state or federal laws for each test ordered and (2) the ordering physician has authorization from the patient permitting MLabs to report results for each test ordered to the ordering physician.

PATIENT HISTORY/DIAGNOSIS

Diagnosis: _____ Collection Date: _____ Time: _____ (○am ○pm) Footnote: Case/Accn # _____

Donor specimen, please include:
- ☐ Recipient's full name and/or MRN _____
- ☐ Relationship to Recipient _____
- ☐ Recipient Diagnosis _____

Patient/Recipient specimen
- ☐ Patient has not yet received a transplant
- ☐ Patient has received a transplant

For all Donor Specific Antibody (DSA) testing, an additional unique patient identifier is required for matching in UNOS database. Please provide:
☐ U of M MRN _____ or ☐ Last 4 digits SSN _____

HEMATOPOEITIC CELL TRANSPLANT

☐ New Patient [1]	
HLA High Resolution Typing I&II (HLHR)	Y (2)
Antibody Screen Mixed (HLASM)	R
☐ Patient Confirmatory Typing	
HLA Typing I&II (HLCT)	Y
☐ Donor Confirmatory Typing	
HLA Typing I&II (HLCTD)	Y (2)
☐ New Donor [1]	
HLA Typing I &II (HLBML)	Y (2)
☐ Autologous PRA [1]	
Antibody Screen Mixed (HLASM)	R
☐ Allogenic PRA [1]	
Antibody Screen Mixed (HLASM)	R

DISEASE ASSOCIATION STUDIES

☐ Abavir Hypersensitivity (HLA-B 5701) (ABAC)	Y
☐ Ankylosing Spondylitis (HLA-B27) (ANKYL)	Y
☐ Behcets Disease (HLA-B51) (BEHC)	Y
☐ Bird Shot Retinopathy (HLA-A29) (BSHT)	Y
☐ Carbamazepine Hypersensitivity (HLA- B 1502) (CARB)	Y
☐ Celiac Disease (HLA-DQ2 or DQ8) (CELI)	Y
☐ Narcolepsy (HLA-DQB1 0602) (NARC)	Y
☐ Uveitis (HLA-B57) (UVE)	Y
☐ Other, Specify _____(DIS)	Y

SOLID ORGAN TRANSPLANT (CIRCLE PATIENT TYPE)

KIDNEY HEART LUNG LIVER PANCREAS

☐ Donor Specific Antibody Testing (check one)	
☐ STAT Antibody Specificity Class I & II (HLAS)	R
☐ Routine Antibody Specificity Class I & II (HLAS)	R
☐ New Patient	
HLA Typing I & II (HLLR)	Y (2)
Antibody Specificity Class I & II (HLAS)	R
☐ New Kidney Donor [1]	
HLA Typing I &II (HLSOD)	Y
HLA Crossmatch FLOW (HLFXM)	Y (4)
☐ Living Donor Repeat XM [1]	
HLA Crossmatch FLOW (HLFXM)	Y (4)
☐ Final Pre-Transplant Flow XM with Living Donor [1]	
Samples from Recipient & Donor are both needed	
DONOR HLA Crossmatch FLOW (HLFXM)	Y (4)
RECIPIENT HLA Antibody Specificity Class I & II (HLAS)	R
☐ Endothelial Precursor Cell (Flow XM) [1]	
Samples from Recipient & Donor are both needed	
DONOR HLA Crossmatch Endothelial Precursor (HLEXM)	Y
RECIPIENT HLA Crossmatch Endothelial Precursor	R
☐ MICA Typing (MICAT)	Y
☐ MICA Antibody [1]	
Antibody Screen Mixed (HLASM)	R
☐ C1q Binding HLA Antibody	
Antibody Specificity Class I&II (HLAC1)	R
☐ Monthly PRA [1]	
Antibody Screen Class I &II (HLPRA)	R
☐ Angiotensin II Type I Receptors (AT1R) (HLAT1)	R

HLA TYPING & PRA FOR TRANSFUSION SUPPORT OR PLATELETS

☐ New Patient for Txf Support [1]	
Antibody Screen Mixed (HLASM)	R
☐ New Patient for Platelet Support [1]	
HLA Typing (HLC1L)	Y
Antibody Screen Mixed (HLASM)	R
☐ Update PRA [1]	
Antibody Screen Mixed (HLASM)	R

☐ Other:_____

☐ Other:_____

☐ Other:_____

Specimen Type: R = Red top (SST acceptable) Y = Yellow top (ACD)

Copy Distribution: White – MLabs Histocompatibility Lab Yellow – MLabs SP Pink – Client

Revised: 5-16-2017 B-REFR

[1] By ordering this test, clinician acknowledges that additional reflex testing and/ or pathologist interpretation will be performed and billed at a separate additional charge if indicated.