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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **RECIPIENT INFORMATION** | | | | | | | | | | | | | **SPECIMEN INFORMATION** | | | | | |
| RECIPIENT NAME (LAST, FIRST, MIDDLE) | | | | | | | | | ETHNICITY: | | | | * URGENT | | | LAB USE: | | |
| RECIPIENT SOCIAL SECURITY NUMBER: | | RECIPIENT UCM MEDICAL RECORD NUMBER: | | | | | | | | SEX:   * M | | * F | SPECIMEN TYPE: | | | | | |
| DATE OF BIRTH: | DATE OF LAST TRANSFUSION: | | | | **ICD-10 CODE (Required):**  **Notice to ordering physician: Medical necessity for the test(s) requested must be indicated by ICD-10 codes.** | | | | | | | | ❑ Blood | ❑ Lymph Node | | | ❑ Spleen | ❑ Other |
| **TRANSPLANT TYPE:**  **□** Heart  **□** Lung **□** Kidney **□** Liver **□** SM Bowel  **□** Bone Marrow **□** Other **\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | **❑ PRE-TRANSPLANT TESTS**  **❑ POST-TRANSPLANT TESTS** | | | | | COLLECTION DATE: | | TIME: | | BY: | |
| **OTHER PROCEDURES / INSTRUCTIONS / REASON FOR TEST:** | | | | | | | | | | | | |
| **❑ REJECTION ❑ DYSFUNCTION** | | | **POST TRANSPLANT DRUG THERAPY:**  \_\_ rituximab \_\_ thymoglobulin \_\_ IVIG  ­\_\_ campath other: \_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | **BILLING INFORMATION** | | | | | |
| UNIVERSITY OF CHICAGO AUTHORIZATION NUMBER: | | | | | |
| **DONOR INFORMATION** | | | | | | | | | | | | |
| **DONOR NAME /UNOS ID (Required):** | | | | **TRANSPLANT DATE (Required):** | | | | | | | | | UIC CODE:  **MX00217** | | | | | |
|  | | | |  | | | | | | | | | Lori Berg  University Of Chicago  Clinical Labs Service Center, MC0006  5841 S. Maryland Ave TW005  Chicago, IL  Phone: (773) 702-1316 Fax: (773) 702-9308 | | | | | |
| **ORDERING PHYSICIAN INFORMATION** | | | | | | | | | | | | |
| **NAME:** | | | | | | **­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­ SIGNATURE:** | | | | | | |
| **Phone #** | | | | | | **FAX #** | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **FAX REPORT TO:** | | | | | | | **MAIL REPORT TO:** | | | | **SEND REQUISITION AND SPECIMENS TO:** | | | | | | | |
| University of Chicago Clinical Labs  **❑ STAT Notification: Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Fax# (773) 702-9308 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | University of Chicago Medicine  Clinical Labs Service Center  5841 S. Maryland Ave. TW005  Chicago, IL 60637  Phone (773) 702-1316 | | | | UCLA Immunogenetics Center  1000 Veteran Avenue, Room 1-308  Los Angeles, CA 90095  Phone: (310) 206-0258 Fax: (310) 794-5652 | | | | | | | |

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|  | **Test No.** | **Test Name** ❑ **STAT** | **INSTRUCTIONS FOR BLOOD DRAW:**  **STORE SPECIMENS AT ROOM TEMPERATURE**  **Send samples to be received within 24 h of draw.** |
|  |  | **ANTIBODY IDENTIFICATION** |  |
| ❑ | 310056 | MICA antibody | Adult: 7-10 mL red top tube, whole blood, send ambient  Pediatric: 3 mL red top tube, whole blood, send ambient |
| ❑ | 310079 | Anti-Angiotensin Type 1 Receptors (AT1R) |
|  |  |  |
|  |  | **MOLECULAR TYPING** |  |
| ❑ | 250055 | MICA genotype | Adult: 7-10 mL ACD\* tube (yellow top) send ambient  Pediatric: 3 mL ACD\* tube (yellow top) send ambient |
|  |  | **CROSSMATCH** |  |
| ❑ | 420060 | Endothelial Cell Crossmatch | Adult: 7-10 mL red top tube, whole blood, send ambient  Pediatric: 3 mL red top tube, whole blood, send ambient |
| ❑ | 420068 | Donor Specific Precursor Endothelial Cell Crossmatch (XM-One) \* | \*7-10 mL red top tube (**patient)** send ambient  \* 4x10 mL ACD tubes(**donor**) send ambient |
|  |  | **\* NEED PATIENT AND DONOR SAMPLES** |
|  |  | **\* Must arrive within 2 days, and by 3 pm on Fridays** |
|  |  |  |
|  |  |  |  |
| ❑ | Other |  |  |