Indiana University Health

Transplant Immunology Laboratory
Methodist Hospital
1701 N. Senate Blvd, Indianapolis, IN 46202
Telephone 317-962-6196, FAX 317-962-6195
CLIA# 15D0662523

TRANSPLANT IMMUNOLOGY REQUISITION

(RETURN THIS FORM WITH BLOOD SAMPLE)

Name of person being drawn:_____

Social Security #_____ MRN_____

Date of Birth:_____ ICD-9 _____

Test request: Coordinator: _____

___ HLA Initial RENAL and/or PANCREAS evaluation (1 red, 4 ACD)
Please provide the following information for any evaluation for KI, PA, MVT &/or LI:
Pregnancies: _____ # Transfusions: _____ Prev Txp _____

___ HLA Initial Liver evaluation (1 red, 1 ACD)

___ HLA Initial Multivisceral evaluation (also for liver/kidney, liver/pancreas) (1 red, 4ACD)

___ HLA Monthly PRA (1 red)

___ HLA Potential Living donor evaluation (1 red, 4 ACD)
Recipient name _____
Donor relationship to recipient _____

___ **Final Crossmatch, Living Donor:**
____ Recipient: HLA Final Renal and/or Pancreas Crossmatch Recipient
____ Donor: HLA Crossmatch Living Donor

___ **Intermediate Crossmatch, Living Donor**: (recipient 1 red, 4 ACD)
____ Recipient: HLA Intermediate Renal and/or Pancreas Crossmatch Recipient
____ Donor: HLA Crossmatch Living Donor (4 ACD)

___ HLA Post Transplant Immunologic Eval (1 red)

___ HLA Immuknow (1 sodium heparin green top)

Authorized Signature: _____ Date_____

SEND TO METHODIST HLA LAB VIA IU SPECIMEN RECEIVING. TUBE TO 260

When ordering tests for Medicare or Medicaid patients, please select only those tests that are medically necessary for the diagnosis or treatment of the patient. Medicare does not pay for routine screening tests,