Versiti does NOT bill patients or their insurance. Call 800-245-3117 ext. 6250 for your Client#.

Person Completing Requisition:	
Institution: Client #	
Dept: Physician/Provider:	
Address:	
City: ST: ZIP:	
Phone (Lab): Phone/Email (Provider)	
Special Reporting Requests:	**PO#:**

Histocompatibility Lab-Versiti WI
Engraftment / Chimerism Testing
Phone 800-245-3117 x 6201 / Fax (414) 937-6322

MEDICARE

Is testing for outpatient Medicare enrollee or Wisconsin Medicaid recipient? **Yes ☐** **No ☐**
If yes, please complete and attach our beneficiary form located at www.versiti.org/medical-professionals/products-services/requisitions

PATIENT INFORMATION

Last Name:	**First Name:**	**MI:**	**DOB:**
MR#:	**Accession#:**	**Draw Date:**	
Gender: ☐ Male ☐ Female		**Draw Time:**	
Ethnic Background (check all that apply): ☐ Caucasian ☐ African American ☐ Hispanic/Latino ☐ Asian ☐ American Indian ☐ Other			

Specimen Type: ☐ Blood ☐Buccal Swabs ☐ Bone Marrow ☐ DNA ☐ Umbilical Cord Blood ☐Other _____
Anticoagulant: ☐ EDTA ☐ ACDA ☐ ACDB ☐ Sodium Heparin ☐ Other _____

REQUIRED FOR ALL ENGRAFTMENT TESTING (please complete all fields):

Diagnosis:_____

Previous Transplant? ☐ Yes Type:_____ Date:____/____/____ Transplant Center: _____

☐ No Anticipated Transplant Date:_____ ☐ Bone Marrow ☐ Solid organ ☐ Other_____

Sample is from: ☐ Recipient Donor Name:_____ Donor Date of Birth:_____

Donor Sex (Circle One): M or F Relationship to Recipient:_____

☐ Donor Recipient Name:_____ Recipient Date of Birth:_____

Recipient Sex (Circle One): M or F Relationship to Donor:_____

Tests

Pre-Transplant Engraftment/Chimerism Testing

☐ Recipient specimen (4020)
☐ Donor specimen (4040)

Twin Zygosity Testing

☐ Recipient specimen (4060)
☐ Donor specimen (4070)

Erythroid Chimerism

☐ Erythroid Chimerism (4250)
Donor Genotype_____☐AA ☐AS (Required)
Genotype_____☐SS ☐AS (Required)

Post-Transplant Engraftment/Chimerism Testing

☐ Engraftment on blood sample (4220)
☐ Engraftment on bone marrow (4222)

Engraftment/Chimerism on Enriched Cell Populations
☐ CD3 & CD33 cells (2044)
☐ CD3 & CD33 & CD56 cells (2045)
☐ CD19 & CD56 cells (2046)
☐ CD3 cells (2040)
☐ CD33 cells (2041)
☐ CD19 cells (2042)
☐ CD56 cells (2043)

Engraftment on Other Sample Types:
☐ Prepare MNC, chimerism (2048)

Sickle Cell Disease

☐ Hemoglobin SC Mutation Analysis (4624)

STAT TESTING

☐ **STAT Testing**
(Fee required)
Results Required By:
Date:_____
Time: _____
Timeframe for results:
Blood/BM - 48 hrs | Sorted cells - 72 hrs

Versiti Use Only

__ ACDA HEPB
__ ACDB buccal swabs
__ EDTA
__ Other:
Opened By: _____
Evaluated By: _____
Reviewed By: _____
Labeled By: _____

Tubes must be **individually** labeled with the **FULL NAME OF THE INDIVIDUAL, ANOTHER IDENTIFIER (e.g., SSN, MRN, DOB), DATE AND TIME OF COLLECTION**.

Samples cannot be accepted after any exposure to an environment in which HLA genes are amplified. This precaution is essential to avoid contamination of samples with DNA that could alter test results.

Samples will be accepted from 8:00 a.m. Monday through 12:00pm Friday. Emergency testing **MUST** be arranged through the laboratory. Call (414) 937-6201.

Cell sort specimens for post-transplant chimerism monitoring must be received within 24 hours of collection to ensure cell viability.

<table>
<tr><th>Test</th><th>Sample Type</th><th>Store and Ship</th></tr>
<tr><td>Erythroid Chimerism</td><td>3-5 mL EDTA Bone Marrow (lavender top) OR
10 mL EDTA Whole Blood (lavender top)</td><td>Room temperature via an overnight courier. Samples must be received within 48 hours of being drawn.</td></tr>
<tr><td>Hemoglobin SC Mutation Analysis</td><td>FETAL: 7-15 mL Amniotic Fluid or 5-10 mg CVS, backup culture of Amniocytes or CVS is highly recommended;
Two T25 flasks Cultured Amniocytes or CVS (2x10^6 minimum)
PARENTAL & PATIENTS: 3-5 mL EDTA whole blood (lavender top). Maternal sample for maternal cell contamination
1µg DNA (25ng/µl and 25µl)</td><td>Room temperature.</td></tr>
<tr><td>Engraftment/Chimerism</td><td>Pre-transplant Recipient and Donor:
•5 ml whole blood or marrow
•Collection tube anticoagulants EDTA, Na Heparin, or ACDA
OR
•4-8 Buccal swabs each
Post-transplant (Recipient):
•5 ml whole blood or marrow
•Collection tube anticoagulants EDTA, Na Heparin, or ACDA
•Cells: Contact Laboratory for requirements</td><td>Room temperature.</td></tr>
<tr><td>Cell Sort Enrichment
CD3, CD19, CD33, CD56</td><td>•Collection tube anticoagulants EDTA, Na Heparin, or ACDA
<table><tr><th>Cell Enrichment</th><th>Required Volume Blood or Marrow</th></tr><tr><td>CD3 or CD33</td><td>4ml</td></tr><tr><td>CD3 & CD33</td><td>8ml</td></tr><tr><td>CD19 or CD56</td><td>8ml</td></tr><tr><td>CD19 & CD56</td><td>16ml</td></tr><tr><td>CD3 & CD33 & CD56</td><td>16ml</td></tr></table></td><td>Room temperature. Samples must be received within 24 hours of draw and may be drawn Monday through Thursday for delivery Tuesday through Friday.</td></tr>
<tr><td>Twin Zygosity</td><td>5 mL EDTA whole blood or bone marrow OR 4-8 Buccal</td><td>Room temperature</td></tr>
</table>

Blood samples should be shipped by overnight carrier. The package must be shipped in compliance with carrier's guidelines. Please contact your carrier for current biohazardous shipping regulations.

Shipping address: Versiti Wisconsin – Histocompatibility Laboratory
638 N. 18th Street
Milwaukee, WI 53233
Phone: (414) 937-6201

Label Box: Refrigerate, Room Temperature, or Frozen (whichever is appropriate)