

HISTOCOMPATIBILITY REQUISITION

IMMUNOGENETICS LABORATORY
JOHNS HOPKINS UNIVERSITY
2041 E. MONUMENT STREET
BALTIMORE, MD 21205
TEL: 410-955-3600
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RECIPIENT
NAME:

SSN:

History #:

DRAW DATE:

SAMPLE INFORMATION:

LAST NAME:

FIRST NAME:

SOCIAL SECURITY #:

HOSPITAL ID#:

BIRTH DATE:

SEX:

RACE:

HOSPITAL:

SERVICE:

BLOOD TYPE:

PHYSICIAN:

DIAGNOSIS:

PATIENT

POTENTIAL DONOR

DONOR RELATIONSHIP TO PATIENT:

IF THIS IS A POTENTIAL DONOR FILL IN RECIPIENT INFORMATION AT THE TOP OF THIS FORM

TEST REQUESTED:

TYPING:

LR Class I
 HR Class I
 LR Class II
 HR Class II

SAMPLE REQUIRED:

4 x 10ml ACD* TUBE

ANTIBODY TESTING:

SCREEN

CROSSMATCH

SAMPLE REQUIRED:

10ml CLOT

SENSITIZATION INFORMATION, IMMUNOSUPPRESSIVE THERAPIES & OTHER COMMENTS:

PREVIOUS GRAFTS

TRANSFUSIONS

PREGNANCIES

IMMUNOSUPPRESSIVE THERAPIES

COMMENTS

GENERAL INSTRUCTIONS

ALL SAMPLES MUST BE LABELED WITH NAME, DATE AND IDENTIFIER NUMBER.

ALL TESTS MUST BE REQUESTED BY A PHYSICIAN OR QUALIFIED INDIVIDUAL, WITH REQUESTOR'S NAME ON REQUISITION.

*ACD TUBE: YELLOW TOP WITH ACID CITRATE DEXTROSE SOLUTION.