NJ Sharing Network Transplant Laboratory
CLIA#31DO652894
691 Central Ave, New Providence, NJ 07974
Ph (908) 516 5454 Fax (908) 516 5554

REQUEST FOR HSC IMMUNOGENETIC TESTING

Name: _____ S.S #: _____

D.O.B: _____ Sex as Identified @ Birth: ❑ Male ❑Female Diagnosis: _____

Transplant Center: _____ Physician: _____

Ethnic Ancestry

❑White
❑Native Hawaiian
❑South Asian (Indian/Pak)
❑American Indian
❑ Other: _____
❑Middle Eastern
❑African American
❑Hispanic
❑Asian
Enter where earliest ancestry came from

Patient Category

❑ HSC Patient
❑ HSC Donor
Relationship to recipient: _____

Recipient's Name: _____

❑ Haplo Donor: _____
❑ HLA Matched Platelet
❑ Other: _____

Tests

❑ HLA Class I Low Resolution by DNA
❑ HLA Class I High Resolution by DNA
❑ HLA Class II Low Resolution by DNA
❑ HLA Class II High Resolution by DNA
❑ ABO / Rh
❑ HLA Class I/Class II Antibody Screen and Identification
❑ Confirmatory Typing
❑ Flow Cytometry Crossmatch
❑ Other: _____

Specimen Information

Collection Date: _____ Collected by: _____ Witnessed by: _____

Complete Sensitization History

❑ Pregnancy — How many? _____
❑ Transplant — Date(s)/Source(s): _____
❑ Transfusion — Last transfusion date and Product: _____
❑Desensitizing Protocol — Date(s)/Product: _____
❑Immunosuppressive Regimen — Date(s)/Product: _____
❑Vaccination — Date(s)/Type: _____
❑ Travel History — Date(s)/Place: _____

Patient/Donor Agreement:

❑ I agree with the information provided above.

_____ Patient/Donor Name
_____ Patient/Donor Signature
_____ Date

Revised on: 08/31/2018