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| **REQUESTOR’S INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **PATIENT’S INFORMATION** | | | | | | | | | | | | | | | | |
| **Facility Name:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | **Name:** | |  | | | | | | | |  | | | | |  | |
|  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |  | | Last | | | | | | | | First | | | | Middle | | |
| **Facility Address:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | **Address:** | | |  | | | | | | | | | | | | | |
| Street, Room No. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Street** | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | |  | |  | | | | |
| City/Town | | | | | | | | | | | | | | | | | Province | | | | | | | | | | | Postal Code | | | | | | **City/Town** | | | | | | | | | | **Province** | | **Postal Code** | | | | |
| **Clinic:** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | **Hospital ID No. (CR No.):** | | | | | | | | | |  | | | | | | |
| **Phone Number:** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | **Health Card Number (HCN):** | | | | | | | | | |  | | | | | | **V:** |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Health Card Province:** | | | | | | |  | | | **Exp Date:** | | |  | | | |
| **Ordering Physician:** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | YYYYMMMDD | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | Print | | | | | | | | | | | | | | | | | | | | | | | **DOB:** | |  | | | | | | | | 🞏 **Male** | | | 🞏 **Female** | | | |
| **Physician Signature:** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |  | | YYYYMMMDD | | | | | | | |  | | |  | | | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | **Clinical Information:** | | | | | |  | | | | | | | | | | |
| **Specimen Collected by:** | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | |  |  | | | | | | | | | | | | | | | |
| **Date:** | | | | | |  | | | | | | | | | | | **Time:** | | | | | | | | | | |  | | | |  | | **Relevant Medications:** | | | | | |  | | | | | | | | | | |
|  | | | | | | YYYYMMMDD | | | | | | | | | | |  | | | | | | | | | | |  | | | | | |  |  | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SOLID ORGAN TRANSPLANT (Kidney)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | **STEM CELL & BONE MARROW TRANSPLANT** | | | | | | | | | | | | | | | | |
| **Recipient Clinical Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Clinical Diagnosis: | | | | | |  | | | | | | | | | | |
| TGLN No.: | | | | |  | | | | | | | | | | | CTR No.: | | | | | | | | | |  | | | | | | | 🞏 Recipient | | | | | | | | | | 🞏 Donor | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | If testing for a donor provide the recipient information below: | | | | | | | | | | | | | | | | |
| Sensitization History: | | | | | | | | | # Transfusions: | | | | | | | | | | | | |  | | | # Pregnancies: | | | | | |  | | Recipient Name: | | | | | | | | | |  | | | | | | |
|  | | | | | | | | | Date of Last: | | | | | | | | | | | | |  | | | | | | | | | | | Recipient HCN: | | | | | | | | | |  | | | | | V: | |
| Previous Transplants: | | | | | | | | | 🞏 No | | | | | | | | | | | | | | | 🞏 Yes | | | | | | | | | Relationship to Recipient: | | | | | | | | | |  | | | | | | |
|  | | | | | | | | | Date of Last: | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| Immunosuppressive Therapy: | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | HLA Typing (select) | | | | | EDTA Lavender Top Peripheral Blood | | | | | | | | | | | |
| 🞏 None | | 🞏 ATG | | | | | | | | 🞏 IVIG | | | | | | | | 🞏 Rituximab | | | | | | | | | | | 🞏 PLEX | | | | 🞏 Potential Donor Intermediate Resolution Screening (in house) | | | | | | | | | | | | | | | | |
| 🞏 Other: | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 🞏 High Resolution HLA Typing\* | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | \* include transplant centre requisition | | | | | | | | | | | | | | | | |
| **Donor Information** | | | | | | | | | | | | | | | 🞏 Live | | | | | | | | 🞏 Cadaveric | | | | | | | | | | 🞏 HLA Antibody Testing | | | | | | | | 1 Red Top Peripheral Blood | | | | | | | | |
| TGLN No.: | | | | | |  | | | | | | | | | | | CTR No.: | | | | | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | |
| Recipient Name: | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | **Autoimmune Disease Association** | | | | | | | | | | | | | | | | |
| Recipient | | | | TGLN No.: | | | | | | | | | |  | | | | | | | CTR No: | | | | | | | | |  | | | Clinical History: | | | |  | | | | | | | | | | | | |
| Relationship to recipient: | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | Specimen Type: | | | | EDTA Lavender Top Peripheral Blood | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 🞏 HLA-B27 – Ankylosing Spondylitis | | | | | | | | | | | | | | | | |
| **Testing Required** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 🞏 HLA-B\*57:01 – Abacavir Sensitivity | | | | | | | | | | | | | | | | |
| 🞏 **HLA Typing** | | | | | | | | | EDTA Lavender Top Peripheral Blood | | | | | | | | | | | | | | | | | | | | | | | | 🞏 HLA-DQ2/DQ8 – Celiac Disease | | | | | | | | | | | | | | | | |
| HLA Antibody Testing | | | | | | | | | 1 Red Top Peripheral Blood | | | | | | | | | | | | | | | | | | | | | | | | 🞏 HLA-A29 – Birdshot Chorioretinopathy | | | | | | | | | | | | | | | | |
| 🞏 **SAg** | | | | | | | | | 🞏 **DSA** | | | | | | | | | | TGLN Donor No.: | | | | | | | | | | | | | | 🞏 Other Locus: | | | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Suspected Association: | | | | | | |  | | | | | | | | | |
| 🞏 **Flow Crossmatch** | | | | | | | | | | | | 🞏 Live Donor | | | | | | | | | | | 🞏 Cadaveric Donor | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| 🞏 Initial | | | | | | 🞏 Final | | | | | | | | | | | 🞏 Virtual | | | | | | | | | | 🞏 Auto | | | | | | **HLA Testing for Matched Platelets** | | | | | | | | | | | | | | | | |
| Recipient: | | | 1 Red Top Peripheral Blood | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 🞏 HLA Typing | | | EDTA Lavender Top Peripheral Blood | | | | | | | | | | | | | |
| Donor: | | | 4 X ACD Soln A Peripheral Blood | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 🞏 HLA Antibody Testing | | | | | | | | 1 Red Top Peripheral Blood | | | | | | | | |