

**SAMPLES ARE TO BE SENT TO:**

Transplantation Immunology Laboratory  
Hoxworth Blood Center  
University of Cincinnati Academic Health Center  
3130 Highland Ave PO Bx 670055  
Cincinnati, OH 45267-0055

**TID Requisition****Bone Marrow Transplant Requisition**

Hospital: \_\_\_\_\_

Test Priority: \_\_\_\_ Stat \_\_\_\_ Routine

Diagnosis: \_\_\_\_\_

Ordering Physician:

Last \_\_\_\_\_ First \_\_\_\_\_

Address \_\_\_\_\_

Person Completing Requisition:

\_\_\_\_\_ Date \_\_\_\_\_

Phlebotomy: I have drawn this blood specimen, reconciled the label with the patient's wristband and attached the label to the specimen before leaving the patient.

Signature: \_\_\_\_\_

Encounter #

DOB/Age/Sex

Name

MRN

Patient Address:

City, State, Zip

Relationship:

Comments:

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BONE MARROW RECIPIENT TESTING		
	HBMFR	<b>BONE MARROW TRANS FAM RECIPIENT</b> T51, T33 20 mL EDTA
	HBMRR	<b>BONE MARROW - REGISTRY RECIPIENT</b> T33(4) 20 mL EDTA
	HDABHR	<b>DNA ABC HIGH RESOLUTION</b> T33(3) 20 mL EDTA
	HDDRRLRM	<b>DNA DR LOW RESOLUTION</b> T31 10 mL EDTA
	HDDRHRM	<b>DNA DR HIGH RESOLUTION</b> T33 10 mL EDTA
	HPRAC	<b>PRA - HLA Ab SCRIN (CYTOTOXIC)</b> T58 10 mL Plain Red Top
	HPRAFTB	<b>PRA - HLA FLOW SCRIN CLASS I &amp; II (T-CELL &amp; B-CELL)</b> T58(2) 10 mL Plain Red Top
	HSLLR	<b>HLA SPECIFIC LOCUS TYPING -LOW RESOLUTION (SPECIFY LOCUS)</b> T52 10 mL EDTA
	HSLHR	<b>HLA SPECIFIC LOCUS TYPING -HIGH RESOLUTION (SPECIFY LOCUS)</b> T33 10 mL EDTA
	HFCCMR	<b>FLOW CYTOMETRY CROSSMATCH RECIPIENT</b> T61(2) 10 mL Plain Red Top
	HLAXMR	<b>CYTOTOXIC CROSSMATCH RECIPIENT</b> T61 10 mL Plain Red Top
	HLACHIM	<b>CHIMERISM TESTING</b> T35 10ml EDTA

BONE MARROW DONOR TESTING		
	HBMFD	<b>BONE MARROW FAMILIAL DONOR</b> T51, T33 20 mL EDTA
	HBMRD	<b>BONE MARROW - REGISTRY DONOR</b> T33(4) 20 mL EDTA
	HDDRHRM	<b>DNA DR HIGH RESOLUTION (IF ABC MATCH)</b> T33 10 mL EDTA
	HSLLR	<b>HLA SPECIFIC LOCUS TYPING -LOW RESOLUTION (SPECIFY LOCUS)</b> T52 10 mL EDTA
	HSLHR	<b>HLA SPECIFIC LOCUS TYPING -HIGH RESOLUTION (SPECIFY LOCUS)</b> T33 10 mL EDTA
	HFCCMD	<b>FLOW CYTOMETRY CROSSMATCH DONOR</b> 40 mL ACD (charge for this test is covered under the recipient testing)
	HLAXMD	<b>CYTOTOXIC CROSSMATCH DONOR</b> 40 mL ACD (charge for this test is covered under the recipient testing)

**For Billing Purposes Please Complete  
Recipient Name:**

\_\_\_\_\_