UAMS Tissue Typing Laboratory
Department of Pathology
4301 West Markham, M1/300
Little Rock, AR 72205
501-686-7257
Attn: Bobbie Rhodes-Clark

REQUEST FOR CLINICAL TESTS

Completed Form Must Accompany Specimens

*Transplant Hospital:	*Medical Record:
***Patient's Name**:	Social Security No:
	*DOB/SEX/RACE:
Diagnosis:	Requesting Physician:
***Donor's Name:**	***Relationship to Recipient:**
	*DOB/SEX/RACE:
Signature of person requesting test:	
Report to be sent to:	
To be filled out by Phlebotomist	
Time Sample Drawn: Date: By:	

**** Must be completed on every recipient or donor sample submitted.***

REQUIRED SPECIMEN

DO NOT REFRIGERATE; *MUST ARRIVE IN HLA LAB WITHIN 24 HOURS*

Please do not ship or mail samples to the HLA Lab on Thursday or Friday

PLEASE CHECK ALL THAT APPLY:		
	HLA-A, B, C, DR, DQ Typing Molecular method	**20 mls-in ACD-Yellow Top Tubes**
	FLOW CROSSMATCH	***RECIPIENT/PATIENT*:** **10 mls in Red Top Tube** **10 mls in ACD-Yellow Top Tube**
		DONOR: **20 mls in ACD-Yellow Top Tubes**
	FLOW CROSSMATCH-*** **(Preliminary for HLA Lab and Renal Coordinators use only)**	***Additional blood is not needed on recipient or donor if a CROSSMATCH is ordered with initial HLA Typing. Please call HLA-Lab if assistant is needed-501-686-7257*.**
	PRA (Single Antigen, Antibody Screen, Cytotoxicity antibody Screen)	**10 mls in Red Top Tube**

Please Indicate:

Previous Transplant? Yes or No **Transfusion? Yes or No**

Date of Previous Transplant: ___________ **Date of Transfusion(s): ______________________**

Number of Pregnancies: _______________

Medications: ____

******Please Note*******

Routine testing is performed Monday –Friday. Routine samples received after 12:00 noon on Fridays will be processed on the following Monday.