Community Blood Center
Community Tissue Services®

HLA Laboratory Requisition Form

Tel (937) 461-3295 Fax (937) 461-2738

PATIENT/DONOR INFORMATION				
Name(Last, First):	ID:	DOB:	Sex:	Race:

Donor for:/ NA	Relationship to Pt:/ NA	Physician:	Institution:
Diagnosis:		☐ Diagnostic ☐ HLA Selected Platelets ☐ Other	
If Abnormal: % Lymphocyte WBC Count			
Sample Collection	Date:	Time:	Collected by:

MINIMUM SAMPLE REQUIREMENTS	
HLA- B27	**10 ml Sodium Heparin *DO NOT REFRIGERATE***
DNA Typing	**7ml EDTA**
Antibody ID	**10 ml Plain Red Top (Serum Separator Tubes are NOT acceptable)**

Contact Hospital Services (937) 461-7557 for specimen pickups

Samples will *NOT* be accepted after *12:00 Noon* on Fridays without prior approval

Samples should be received within 24 hours of collection

TEST REQUESTED	
☐ HLA-B27 (701, 729)	☐ DNA-DR,DR345 (Class II)(751)
☐ DNA-A,B,C (Class I)(753)	☐ DNA-DQ (Class II)(723)
☐ TRALI Workup (728)	☐ DNA-Single Locus- A B C(754)
☐ Other	☐ After hours (951) extended(951s)
Comments:	

HLA Laboratory Use ONLY

Received: Date: Time: By:	Volume:	Log #: