Fred Hutch Cancer Center

Please affix collection facility sample label if available.

Clinical Immunogenetics Laboratory
Phone 206-606-7700, Fax: 206-606-1169
Requisition For HLA Testing-Hospital/Clinic Collection
F1095.18, Effective Date: 10/7/2022

Requisition For HLA Testing-Hospital/Clinic Collection

1. All specimen tubes or swabs must be labeled with a **name** and a **date of birth** or the sample cannot be accepted.
2. A completed requisition is required to accompany each individual's sample.

Person from whom sample is being collected:

(Full Legal Name Required)

Last:_____ First:_____ Middle:_____ Suffix:_____

Date of birth: _____Sex assigned at birth: _____Gender: _____

Contact phone: (optional) _____ Email: (optional)_____

Relationship to potential recipient (circle): Recipient (Self) Sibling Half-Sibling Child Parent Other_____

Legal guardian (if sample is collected from a minor):

Name (please print):_____Relationship:_____

I have verified:
1. This sample was collected from the person listed above and
2. Each sample tube or swab is labeled with the persons full name, date of birth, and collection date.

_____ _____

(Signature) (Print your name)

Name of Facility (where specimen was collected): _____ Phone:_____

City:_____ State:_____ Sample Type: ☐ Blood ☐ Buccal ☐ Saliva

Collection date: _____ ***Collection time:*** _____

Potential transplant recipient information:

Last:_____First:_____Middle:_____Suffix:_____

Date of birth: _____Diagnosis: _____ ICD-10_____

Referring provider: _____Provider phone:_____

Clinical Immunogenetics Laboratory
Director: Gana Balgansuren MD, PhD
Phone: 206-606-7700
Fax: 206-606-1169
Email: CILLABCO@seattlecca.org
CLIA Number: 50D0995557
F1090.10 Revised by: dc
Effective Date: 10/7/2022

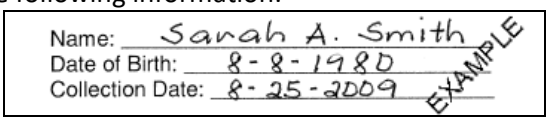
Blood Collection & Shipping Instructions for Hospital/Clinic Collection

1. All specimen tubes must be labeled with a **name** and a **date of birth,** or the sample cannot be accepted.
2. A completed requisition is required to accompany each individual's sample.

Contact CIL (206-606-7700/CILLABCO@seattlecca.org) before sample collection or with any questions.

Labeling Instructions: Each tube must be clearly labeled with the following information:

- **Full name**
- **Date of Birth**
- **Draw Date**



Requisition Requirements: Please complete a requisition form (**Requisition For HLA Testing F1095**) for each individual's samples collected and send a requisition form with the samples.

Name of person being drawn: _____

Relationship to potential transplant recipient: Recipient (Self)

Name of potential transplant recipient _____

Reason for sample collection: Potential Transplant Recipient

Sample Requirements (Please collect both heparinized blood and clot tube)

_____ mLs sodium heparinized blood (usually green top tubes)

_____ mLs of clotted blood (usually red top tubes)

If sodium heparin blood collection tubes are unavailable lithium heparin or ACD solution A can be used. Please contact the laboratory at 206-606-7700 for further instruction.

Packaging: Specimens should be sent to the CIL in a manner that insures the sample container will not be broken and in accordance with federal, state, and local guidelines on handling of potentially infectious materials (e.g. Universal Precautions for handling bodily fluids).

Shipping Instructions: Ship samples at **room temperature** to arrive in our laboratory within 48 hours after draw. ***Please contact our office prior to shipping the samples.*** We accept samples Monday through Thursday between 8:30 a.m. & 5:00 p.m. Friday samples must be received before 2:30 p.m. Our lab is closed on weekends and holidays.

SHIP TO:
Fred Hutch Cancer Center
Attn: CIL/HLA Room 2120
188 E. Blaine, St., Suite 250
Seattle, WA 98109-1023

CONTACT INFORMATION:
Email: CILLABCO@seattlecca.org
Phone: 206-606-7700
Fax: 206-606-1169

Comments: _____