

REQUEST FOR TISSUE TYPING DIAGNOSTIC TESTING

- Disease Association
- Hypersensitive Drug Reactions

New Zealand Transplantation and Immunogenetics Laboratory (NZTIL)

NZ Blood Service
71 Great South Road
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Auckland 1051
NEW ZEALAND
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NZTIL use only:

Received by _____ Registered by _____

Event No. _____

FULL AND ACCURATE COMPLETION OF THIS FORM IS ESSENTIAL

Step 1. PATIENT/DONOR DETAILS <i>(Attach identification label or complete all written details)</i>		
Family Name _____		
Given Names _____		
NHI _____	Date of Birth _____	Gender _____
Ward _____	Hospital _____	
(FOR URGENT TEST REQUESTS PLEASE PHONE NZTIL – (09) 523 5731)		
Step 2. TESTING REQUIREMENTS - see reverse for sample requirements		
Disease Association <input type="checkbox"/> Ankylosing Spondylitis (HLA-B27) <input type="checkbox"/> Bechet's Disease (HLA-B5 / B51) <input type="checkbox"/> Birdshot Retinopathy (HLA-A29) <input type="checkbox"/> Coeliac Disease (HLA-DQ2/DQ8) <input type="checkbox"/> Narcolepsy (HLA-DQB1*06:02) <input type="checkbox"/> Other – please specify: _____	Hypersensitive Drug Reaction <input type="checkbox"/> Carbamazepine/Tegretol (HLA-A*31:01) and/or <input type="checkbox"/> Carbamazepine/Tegretol (HLA-B*15:02) <input type="checkbox"/> Abacavir (HLA-B*57:01) <input type="checkbox"/> Allopurinol (HLA-B*58:01) <input type="checkbox"/> Other – please specify: _____	
If request is part of a Clinical Trial, please state the name below: Clinical Trial Name _____ HLA gene testing requirements if not listed above – please specify _____		
Step 3. NAME OF REQUESTING PRACTITIONER / COORDINATOR		
Practitioner / Coordinator / Nurse: _____ Signature: _____		
Contact Ph: _____ Date: _____ DHB: _____		
Full Address: _____		
Email Address: _____		
Step 4. SPECIMEN COLLECTOR DECLARATION		
* I certify that the blood specimen(s) accompanying this request form was drawn from the patient named above. * I established the identity of this patient by direct enquiry and/or inspection of their wristband. * Immediately upon the blood being drawn I labelled and signed the specimen(s) in the presence of the patient.		
Date/Time of collection: _____ Contact No: _____		
SIGNATURE OF COLLECTOR: _____ Print Name: _____		
Doctor/Coordinator/Nurse (please circle)		

Abbreviation(s)		
DSA = Donor Specific Antibody	MUD = Matched Unrelated Donor	PIFT = Platelet Immunofluorescence Test
HLA = Human Leucocyte Antigen	NAIT = Neonatal alloimmune thrombocytopenia	TRALI = Transfusion Related Acute Lung Injury
HPA = Human Platelet Antigen	NAT = Nucleic Acid Testing	VXM = Virtual Crossmatch
ITP = Idiopathic Thrombocytopenia Purpura	PAA = Platelet Associated Antibody	XM = Crossmatch

TEST REQUESTS	SAMPLE REQUIREMENTS	SAMPLE CRITERIA
Haematopoietic Cell/Bone Marrow Transplant – patient and donor Initial and confirmatory HLA typing	2 x 9mL CPDA (If cell count low - 4 x 9mL CPDA) and , 1 x 4mL K2E (EDTA) (with initial typing only) and , 1 x 10mL Clotted for patient only	≤ 5 days
Lymphocyte crossmatch (Flow Cytometry)	4 x 9mL CPDA; 1 x 10mL Clotted; 1 x 4mL K2E (EDTA)	≤ 48 hrs.
HLA antibody screen or Donor Specific Antibody (DSA) Testing	1 x 10ml Clotted or 2 x 6ml Clotted	≤ 96 hrs.
Solid Organ Transplant – patient and donor Initial and confirmatory HLA typing	2 x 9mL CPDA and 1 x 4mL K2E (EDTA); and , for patient 1 x 10mL Clotted	≤ 5 days
Lymphocyte crossmatch (Flow cytometry); NAT for donor only	4 x 9mL CPDA and 1 x 4mL K2E (EDTA); and , for donor 1 x 5mL PPT; for patient 1 x 10mL Clotted	≤ 36 hrs.
Virtual Crossmatch VXM Donor	1 x 9mL CPDA; 1 x 10ml Clotted, 1 x 4mL K2E (EDTA) and 1 x 5mL PPT	≤ 5 days
VXM Patient	1 x 9mL CPDA; 1 x 10ml Clotted and 1 x 4mL K2E (EDTA)	≤ 96 hrs.
HLA antibody screen or Donor Specific Antibody (DSA) Testing	1 x 10ml Clotted or 2 x 6ml Clotted	≤ 96 hrs.
Monthly serum sample	1 x 10ml Clotted or, 2 x 6ml Clotted	≤ 96 hrs.
Platelet Immunology & TRALI/Transfusion Reactions Refractory patients (includes HLA/HPA typing if required)	2 x 9mL CPDA and 1 x 10ml Clotted	≤ 36 hrs.
HLA antibody screen only	1 x 10ml Clotted or, 2 x 6ml Clotted	≤ 96 hrs.
NAIT (includes HPA genotyping and maternal/paternal XM)	Mother: 2 x 9mL CPDA and 1 x 10ml Clotted Father: 2 x 9mL CPDA	≤ 36 hrs.
Platelet Antibody screen (PAA and PIFT)	2 x 9mL CPDA and 1 x 10ml Clotted	≤ 36 hrs.
Idiopathic Thrombocytopenia Purpura (ITP) investigation	2 x 9mL CPDA and 1 x 10ml Clotted	≤ 36 hrs.
TRALI/Transfusion Reactions	Donor: 2 x 10ml Clotted; Patient: 2 x 9mL CPDA	≤ 36 hrs.
Disease Association (e.g. B27, Coeliac, Narcolepsy)	1 x 9mL CPDA	≤ 5 days
Hypersensitive drug reaction (HLA-A*31:01, HLA-B*57:01, HLA-B*15:02, HLA-B*58:01)	1 x 9mL CPDA	≤ 5 days

NOTE: FOR A YOUNG PATIENT/DONOR; PATIENTS WITH LOW CELL COUNTS OR, WHERE SAMPLE VOLUMES MIGHT BE PROBLEMATIC – CONTACT THE NEW ZEALAND TRANSPLANTATION AND IMMUNOGENETICS LABORATORY AT (09) 523 5731.

SAMPLE LABELLING & ACCEPTANCE CRITERIA
<ol style="list-style-type: none"> Both tube and request form MUST contain the following information: <ul style="list-style-type: none"> Family name and given name(s) NHI No or DOB Date and time of sample collection Request form and sample(s) MUST be signed by physician/transplant coordinator/nurse who collected the samples. Details on tubes MUST match those on the accompanying form.

DELIVERY INSTRUCTIONS FOR NZTIL TEST REQUESTS	
Monday to Friday New Zealand Transplantation and Immunogenetics Laboratory New Zealand Blood Service 71 Great South Road, Epsom 1051 AUCKLAND	After Hours – Weekends and Public Holidays Blood Bank Auckland City Hospital Park Road, Grafton 1023 AUCKLAND

TURNAROUND TIMES			
Haematopoietic Cell/ Bone Marrow Transplant	2 weeks	Renal Transplant List (HLA and ABO)	2 weeks
Family Study		Live Donor Renal workup	2 weeks
MUD Confirmatory HLA typing	2 weeks	Other Solid Organ workup	2 weeks
HLA Type	2 weeks	Antibody Screen	2 weeks
B27 / Disease Association	2 weeks	Deceased Donor Report	2 weeks
Platelet Refractoriness	*1 day – 1 week	Post-Transplant Antibody Monitoring/ DSA	2 days
NAIT	*1 day – 1 week	*Verbal report given within 24 hours	