ALBANY MEDICAL CENTER
DEPARTMENT OF
LABORATORY MEDICINE

NEW SCOTLAND AVENUE
ALBANY, NEW YORK 12208
PH: (518) 262-3070
FAX: (518) 262-6274

PRACTICE NAME/PHYSICIAN/HOSPITAL

ADDRESS

PHONE

FAX

Affix Arrival Label or Complete below:

NAME: DOB: SEX:

ADDRESS:

MR#/SS#: PHYSICIAN:

INSURANCE CO.: PLAN NAME:

SUBSCRIBER: RELATIONSHIP TO SUBSCRIBER:

ID# GROUP #:

SECONDARY INSURANCE CO: PLAN NAME:

SUBSCRIBER: RELATIONSHIP TO SUB: DOB: SEX:

ID#: GROUP #:

PHLEBOTOMIST INITIALS	DATE COLLECTED	TIME COLLECTED

COPY TO:

Inpatient Unit	FAX	PHONE	DIAGNOSIS / ICD10 CODES MANDATORY FOR EACH TEST ORDERED		
			1.	2.	3.

NOTIFICATION TO PHYSICIANS AND OTHER PERSONS LEGALLY AUTHORIZED TO ORDER TESTS FOR WHICH MEDICARE REIMBURSEMENT WILL BE SOUGHT:
MEDICARE WILL ONLY PAY FOR TESTS THAT MEET THE MEDICARE COVERAGE CRITERIA AND ARE REASONABLE AND NECESSARY TO TREAT OR DIAGNOSE AN INDIVIDUAL PATIENT. MEDICARE DOES NOT PAY FOR TESTS FOR WHICH DOCUMENTATION, INCLUDING THE MEDICAL RECORD, DOES NOT SUPPORT THAT THE TESTS WERE REASONABLE AND NECESSARY. MEDICARE GENERALLY DOES NOT COVER ROUTINE SCREENING TESTS EVEN IF THE PHYSICIAN OR OTHER AUTHORIZED PRACTITIONER CONSIDERS THE TESTS APPROPRIATE FOR THE PATIENT.

ALBANY MEDICAL COLLEGE TRANSPLANTATION IMMUNOLOGY LABORATORY-HISTOCOMPATIBILITY (HLA) TEST REQUISITION

Date of Last Transfusion: ____/____/_____ Race: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Other:_____
Females: # of Pregnancies:_____ # of Births:_____

Current Meds: ☐ TMG ☐ OKT3 ☐ Cyclosporine ☐ FK506 ☐ Rapamune ☐ MMF ☐ MEDROL ☐ Imuran ☐ Prednisone ☐ Procainamide

HLA Matched Platelet Transfusion Support: *(Specimens can be drawn and sent anytime)*

PTHLA	☐	HLA TYPING PATIENT	*2 x 10 ml Yellow Top Tubes*
PTABS	☐	HLA ANTIBODY SCREEN	*1 x 10 ml Glass Red Top Tube*

Bone Marrow / Stem Cell Transplant: *(Schedule family studies at least one day in advance)*

BMABS	☐	HLA ANTIBODY SCREEN *Recipient*	*1 x 10 ml Glass Red Top Tube*		
RPABC	☐	DNA-ABC TYPING *Recipient* **(Run)**	*1 x 7 ml Lavender Top Tube*	RFABC ☐	DNA-ABC TYPING *Family Member* **(Run)**
RPDRQ	☐	DNA-DR/DQ TYPING *Recipient* **(Run)**	*1 x 7 ml Lavender Top Tube*	RFDRQ ☐	DNA DR/DQ TYPING *Family Member* **(Run)**

Potential Donor For: _____ Relationship to Recipient: _____

Diagnostic or Disease Association Antigen Tests: *(May be drawn and sent at anytime)*

DDHLA	☐	HLA TYPING ONLY	*2 x 10 ml Yellow Top Tubes*
DDR	☐	DR TYPING ONLY	*3 x 10 ml Yellow Top Tubes*
DB27	☐	HLA-B27 ANTIGEN ONLY	*2 x 10 ml Yellow Top Tubes*

Disease of Interest: _____

Post Transplant Monitoring

DSHL	☐	Donor Specific HLA Antibody Identification by Luminex	*1 x 10 ml Glass Red Top Tube*

Genetic Tests *(Prior Authorization may be Required by Insurances)*

Disease of Interest: _____

HB5701	☐	HLA-B5701 ONLY	*2 x 3 ml Lavender Top Tube*
DDRDQ	☐	DNA-DR/DQ TYPING	*2 x 3 ml Lavender Top Tube*
CDNADQ	☐	DNA-DQA/DQB TYPING	*2 x 3 ml Lavender Top Tube*
HLATD	☐	DNA-DQ TYPING	*2 x 3 ml Lavender Top Tube*
DNAABC	☐	DNA-ABC TYPING	*2 x 3 ml Lavender Top Tube*

Antigen/Allele of Interest: _____

I am the physician counseling the patient named above. I have informed the patient of the nature and limitations of this test and have obtained the patient's consent for the genetic test ordered, which will be retained in the patient's medical record.

Physician signature: _____ Date: _____ Phone #: _____

TESRD	☐	ESRD Specimens	**Pre-Transplant Tracking Codes**	☐	TPRP Pancreas Transplant Specimens