

REQUEST FOR TISSUE TYPING DIAGNOSTIC TESTING

- Disease Association
- Platelet Tests, Transfusion Reaction Investigation
- Hypersensitive Drug Reactions

National Tissue Typing Laboratory

NZ Blood Service
71 Great South Road
Epsom
Auckland 1051
NEW ZEALAND

Telephone: (09) 523 5731
Fax: (09) 523 5761

Tissue Typing use only:

Received by _____ Registered by _____

Event No. _____

FULL AND ACCURATE COMPLETION OF THIS FORM IS ESSENTIAL

Step 1. PATIENT/DONOR DETAILS – sections marked * are mandatory

*(Tick box indicating if detail relate to a patient or donor. Attach identification label or complete **all** written details).*

- Patient Donor implicated in TRALI/Transfusion Reaction

*NHI No. _____ *DOB _____ *Gender _____

Ethnicity _____

*Family Name _____

*DHB of Patient _____

*Given Names _____

*Progesa ID of Donor _____

(TRALI/Transfusion Reaction investigation only)

FOR URGENT TEST REQUESTS PLEASE PHONE TISSUE TYPING – (09) 523 5731

Step 2. TESTING REQUIREMENTS – see reverse for sample requirements

Disease Association

- B27 (ankylosing spondylitis)
 Coeliac Disease (HLA-DQ)
 Narcolepsy (HLA-DR)
 Other – please specify _____

Hypersensitive Drug Reaction

- HLA-B*57:01 (Abacavir)
 HLA-A*31:01 and/or HLA-B*15:02 (Carbamezapine/Tegritol)
 Other – please specify _____

Platelet Immunology & TRALI/Transfusion Reaction

- Platelet (HPA) antibody screen
 NAIT Investigation (includes HPA genotyping and maternal/paternal crossmatch)
 Investigation of Platelet Refractoriness (includes HPA/HLA antibody screen and HLA/HPA typing if required)
 TRALI/Transfusion Reaction
 Other – please specify _____

Step 3. CLINICAL INFORMATION INCLUDING FACTORS WHICH MAY INTERFERE WITH TESTS

Step 4. NAME OF REQUESTING PRACTITIONER / CO-ORDINATOR

Practitioner / Co-ordinator / Nurse: _____ Signature: _____

Contact Ph: _____ Date: _____ DHB: _____

Full Address: _____

Copy report to and Address _____

Step 5. 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/Pager _____

SIGNATURE OF COLLECTOR _____ Print Name _____

Doctor/Co-ordinator/Nurse (please circle)

Abbreviation(s)		
BMT = Bone Marrow Transplant	NAT = Nucleic Acid Testing	SBT = Sequencing Based Typing
CDC = Complement-dependent Cytotoxicity	NGS = Next Generation Sequencing Typing	SOT = Solid Organ Transplant
HPA = Human Platelet Antigen	PAA = Platelet Associated Antibody	SSP = Sequence Specific Primers
HLA = Human Leucocyte Antigen	PIFT = Platelet Immunofluorescence Test	
MUD = Matched Unrelated Donor	PRA = Panel Reactive Antibody	

TEST REQUESTS	SAMPLE REQUIREMENTS	STORAGE TIME
Hematopoietic Cell/Bone Marrow Transplant – patient/donor Initial and confirmatory HLA typing	2 x 10ml CPDA (If cell count low – 4 x 10ml CPDA) 1 x 10ml clotted 1 x 4ml K2E (with initial typing only)	≤ 5 days
Solid Organ Transplant – patient/donor Initial and confirmatory HLA typing Lymphocyte crossmatch (Flow cytometry); NAT for donor only	4 x 10ml CPDA; 1 x 10ml clotted and 1 x 4ml K2E 4 x 10ml CPDA; 1 x 10ml clotted and 1 x 4ml K2E; and 1 x 5ml PPT for donor only	≤ 5 days ≤ 36 hrs
Monthly transplant tray sample / Antibody Screen	1 x 10ml Clotted or, 2 x 6-7ml Clotted	≤ 96 hrs
Disease Association (e.g. B27, Coeliac, Narcolepsy)	1 x 10ml CPDA	≤ 5 days
Platelet Immunology & TRALI/Transfusion Reactions TRALI/Transfusion Reactions Refractory patients (includes HLA/HPA typing if required) NAIT (includes HPA genotyping and maternal/paternal XM)	Donor: 2 x 10ml clotted; Patient: 2 x 10ml CPDA 4 x 10ml CPDA and 2 x 10ml clotted Mother: 4 x 10ml CPDA and 2 x 10ml clotted Father: 4 x 10ml CPDA	≤ 36 hrs ≤ 48 hrs ≤ 36 hrs
Platelet Antibody Screen (PAA and PIFT)	4 x 10ml CPDA and 1 x 10ml clotted	≤ 36 hrs
Hypersensitive drug reaction (HLA-B*57:01, HLA-B*15:02)	1 x 10ml CPDA	≤ 5 days

NOTE: FOR YOUNG PATIENT/DONOR WHERE SAMPLE VOLUMES MIGHT BE PROBLEMATIC – CONTACT THE TISSUE TYPING LABORATORY AT (09) 523 5731.

SAMPLE LABELLING & ACCEPTANCE CRITERIA

- Both tube and request form **MUST** contain the following information:
 - 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 co-ordinator/nurse who collected the samples.
- Details on tubes **MUST** match those on the accompanying form.

DELIVERY INSTRUCTIONS FOR TISSUE TYPING TEST REQUESTS

Monday to Friday Tissue Typing Laboratory New Zealand Blood Service 71 Great South Road Epsom AUCKLAND	After Hours – Weekends and Public Holidays Blood Bank Auckland City Hospital Park Road AUCKLAND
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TURNAROUND TIMES

Bone Marrow Family Study	1 month	Renal Transplant List (HLA and ABO)	2 weeks
MUD Confirmatory HLA typing	2 weeks	Live Donor Renal workup	4 weeks
HLA Type	2 weeks	Other Solid Organ workup	2 weeks
B27 / Disease Association	2 weeks	Antibody Screen (SOT)	4 weeks
Platelet Refractoriness	*1 day – 1 week	Deceased Donor Report	4 weeks
NAIT	*1 day – 1 week	Post Transplant Monitoring	2 days
Platelet Crossmatch	*1 day – 1 week		
HPA Genotype	1 week		

*Verbal report given within 24 hours

TESTS PERFORMED	TECHNIQUE
Haematopoietic Cell/Bone Marrow Transplant Initial and confirmatory HLA Typing patient and donor – HLA-A,-B,-C,-DRB1345,-DQ,-DP	NGS HLA Typing
Solid Organ Transport (SOT) Initial and confirmatory HLA Typing patient and donor – HLA-A,-B,-C,-DRB1345,-DQ,-DP Crossmatch (patient serum v donor cells) HLA Antibody Screening TRALI/Transfusion Reactions	NGS HLA Typing Flow Cytometry/CDC Luminex Luminex and DNA Typing
Platelet Investigation	Flow Cytometry/Luminex and DNA Typing
Disease and Drug Association	HRM/Luminex DNA Typing