

HLA TYPING AND HLA ANTIBODY INVESTIGATION REQUEST FOR STEM CELL TRANSPLANT

ROUTINE
 AS SOON AS POSSIBLE
 URGENT

RECIPIENT PATIENT INFORMATION	
Gender : <input type="checkbox"/> Female <input type="checkbox"/> Male Ethnicity : <input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> First Nation Other/Country: _____ Sampling (Type/Number) : _____ Serum : _____ EDTA: _____ SWAB: _____ DNA: _____ Date (dd-mm-yyyy) : _____ Time (hh:mm): _____ CASE INVESTIGATED AT HEMA-QUEBEC : <input type="checkbox"/> No <input type="checkbox"/> Yes Reference #: _____	Print Health insurance card or record patient's identification (PATIENT'S LAST AND FIRST NAME, DATE OF BIRTH, HEALTH INSURANCE NUMBER and HOSPITAL'S RECORD NUMBER) <div style="text-align: center; font-size: 2em; opacity: 0.3; transform: rotate(-15deg); pointer-events: none;"> Recipient Patient </div>
For Héma-Québec's use # Individu EdgeLab:	IND-00057
Center of transplant: _____ Transplant physician: _____	Hospital: _____ Attending Physician: _____ Permit #: _____
Diagnosis : _____ Patient in remission : <input type="checkbox"/> No <input type="checkbox"/> Yes Stem cell transplanted patient : <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Allograft <input type="checkbox"/> Autograft Date of graft (dd-mm-yyyy): _____	

Request type	HLA typing: <input type="checkbox"/> Initial typing request HLA Antibody (class I and II): <input type="checkbox"/> Pre-graft (Stem Cell) <input type="checkbox"/> Pre-graft confirmation <input type="checkbox"/> Post-graft (Stem Cell) Other (specify): _____		
Nature of request	<table style="width: 100%;"> <tr> <td style="width: 50%; padding: 5px;"> Section For All Hospitals: <input type="checkbox"/> Related <input type="checkbox"/> Pre-graft workup (Autograft) <input type="checkbox"/> Special request or Diagnosis linked to HLA system (Please specify : locus, allele and resolution level needed): _____ </td> <td style="width: 50%; padding: 5px;"> Section For Transplant Centers: <input type="checkbox"/> Related and unrelated if siblings are not compatible <input type="checkbox"/> Unrelated <input type="checkbox"/> Haploidentical </td> </tr> </table>	Section For All Hospitals: <input type="checkbox"/> Related <input type="checkbox"/> Pre-graft workup (Autograft) <input type="checkbox"/> Special request or Diagnosis linked to HLA system (Please specify : locus, allele and resolution level needed): _____	Section For Transplant Centers: <input type="checkbox"/> Related and unrelated if siblings are not compatible <input type="checkbox"/> Unrelated <input type="checkbox"/> Haploidentical
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SIBLINGS		# samples	FATHER / MOTHER		# samples
IND-00057	Last name: _____ First name: _____ DOB/RAMQ: _____ Sampling Date/Time: _____		IND-00057	Last name: _____ First name: _____ DOB/RAMQ: _____ Sampling Date/Time: _____	
Sibling 1			Father		
IND-00057	Last name: _____ First name: _____ DOB/RAMQ: _____ Sampling Date/Time: _____		IND-00057	Last name: _____ First name: _____ DOB/RAMQ: _____ Sampling Date/Time: _____	
Sibling 2			Mother		

Contact: _____ **Phone number :** _____ **Shipping date (dd-mm-yyyy) :** _____

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

HLA TYPING AND HLA ANTIBODY INVESTIGATION REQUEST FOR STEM CELL TRANSPLANT

SAMPLES NEEDED:		<input type="checkbox"/> Verified by Hospital
<p>HLA Typing:</p> <p>If nucleated cell count is $\geq 2 \times 10^9/L$ (normal):</p> <p style="padding-left: 20px;">15mL of blood collected in ≤ 5mL EDTA tubes (lavender), kept at room temperature.</p> <p>If nucleated cell count is $< 2 \times 10^9/L$:</p> <p style="padding-left: 20px;">At least 35mL of blood collected in ≤ 5mL EDTA tubes (lavender), kept at room temperature.</p> <p>If nucleated cell count is $< 1 \times 10^9/L$:</p> <p style="padding-left: 20px;">Use the Héma-Québec buccal swab collection kit.</p> <p>HLA Antibody investigation:</p> <p style="padding-left: 20px;">10 mL of blood collected in no-additive tubes (red) or 5 ml separated serum.</p>	<p>Samples must be labelled with the following information:</p> <ol style="list-style-type: none"> 1. Patient or sibling's name and unique identifying number, date of birth or health insurance number. 2. Date sample was drawn. 3. Initials of the person who collected the sample. <p>NOTE 1: Inadequately labelled samples will <u>not</u> be tested.</p> <p>NOTE 2: Separator gel tubes or serum from separator gel tubes are not accepted.</p> <p>NOTE 3: The serum aliquot tube must be analysed 48h after collection, otherwise the results may not be conclusive.</p>	

SAMPLE SHIPPING PROCEDURE:		<input type="checkbox"/> Verified by Hospital
<ul style="list-style-type: none"> - If necessary, store samples at room temperature before packaging. - Please make sure that samples are packed in a secured protective manner to avoid breakage. - Samples must be shipped at room temperature. <p>For shipments from regions outside Montreal, the laboratory must be given the waybill number and the shipping schedule at the following phone number : (514) 832-5000 or 1-888-666-HEMA (4362) extension: 6300</p> <ul style="list-style-type: none"> - Transportation by TAXI is at the hospital's expense. - Send the filled form with the samples through the blood bank. - Use one request form for each case investigation. 		

Identify the package and make sure that the address is in full view and enclose the ENR-00522 (LSC-ENR-030) form.

Laboratoire de Référence (LR) – HLA laboratory
 4300, rue Garand
 Saint-Laurent (Québec) H4R 2A3
 Phone number: (514) 832-5000 extension 6300
 Fax number: (514) 832-0271
 Toll free 1-888-666-HEMA (4362)
 Business hours: Monday-Friday 7AM to 11PM

TERMS AND CONDITIONS:		<input type="checkbox"/> Verified by Hospital
<p>The terms and conditions set out below apply to HLA typing and antibody investigation (hereinafter the "Analysis") performed by Héma-Québec's HLA Laboratory for hospitals (hereinafter the "Client"). These terms and conditions supersede and replace the terms and conditions of any purchase order issued by the Client.</p>		
<p>1. <u>Billing and payment</u></p> <p>Where applicable, Héma-Québec shall issue to the Client an invoice identifying, among others, the type and date of the Analysis performed and the applicable rate. The stipulated rate is subject to applicable taxes. Payment must be made by the Client within 30 days following receipt of the invoice. Interest of 1.5% per month (18% per year) shall be applied to any outstanding balance.</p>		
<p>2. <u>Service execution conditions</u></p> <p>Héma-Québec shall perform the Analysis prudently and diligently.</p> <p>As turnaround times may vary according to the type, complexity and urgency of the Analysis to be performed, Héma-Québec is unable to commit itself to provide results within a specific timeframe. Héma-Québec shall make reasonable efforts to send the Analysis results as soon as possible, but cannot be held liable for any damages resulting from a delay in providing the analysis results.</p> <p>Furthermore, Héma-Québec assumes no liability for any action that you might take following receipt of the results.</p>		
<p>3. <u>Confidentiality</u></p> <p>All confidential information exchanged for the purposes of these presents shall be treated as confidential by the parties.</p>		