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
F1095.20, Effective Date: 10-24-2025

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:_____ Suffix:_____

First:_____Middle:_____

Date of birth: _____ Hospital Number/MRN: _____

Sex assigned at birth: _____Gender: _____

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

Relationship to potential recipient (circle):

Recipient (Self) Sibling Half-Sibling Child Parent Other_____

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 ba

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

Potential transplant recipient information:

Last:_____First:_____Middle:_____Suffix:_____

Date of birth: _____Diagnosis: _____ ICD-10_____

Ordering provider: _____ Fred Hutch Cancer Center