



St. Francis

Hospital & Health Centers

Sisters of St. Francis Health Services, Inc.

HLA-Vascular Biology Laboratory

1500 Albany Street, Suite 1109

Beech Grove, IN 46107

Tele: 317 782-7187

FAX: 317 782-6949

REQUISITION FOR HLA TYPING, ANTIPHOSPHOLIPID ANTIBODY ANALYSIS and MATERNAL-ANTIPATERNAL ANTIBODY SCREENING

Use this form for Insurance, Medicare or Medicaid Billing Only

Date: _____ Time Drawn: _____

Patient's name: _____ Sex: M F Spouse's name: _____

Date of Birth: _____ SSN: _____ Marital Status: _____

Home Address: _____ City: _____ State: _____ ZipCode: _____

Home Phone: _____ Employer: _____

FOR THIRD PARTY PAYOR, MEDICAID, OR MEDICARE PATIENTS A COPY OF THE INSURANCE CARD MUST BE ATTACHED

SS# of Insured: _____ Insurance: _____

Policy or Group #: _____ Insurance address: _____

Physician's name: _____ Diagnosis: _____

Physician's Signature: _____

Physician Address: _____

Drawing Laboratory: _____ Phone: _____

_____ Class I HLA typing for disease association (includes HLA-A, B and Cw)
2 10 cc ACD (yellow top) tubes

For purposes of interpretation, please list the HLA antigens or disease for which this test was ordered.

_____ Class II HLA typing for disease association (includes HLA-DR and DQ)
1 10 cc ACD (yellow top) tubes

For purposes of interpretation, please list the HLA antigens or disease for which this test was ordered.

_____ Anticardiolipin antibody analysis (IgG, IgA and IgM)
1 10 cc plain red top tube

_____ Antiphospholipid antibody analysis (anticardiolipin, antiphosphatidylserine, antiphosphatidylethanolamine,
antiphosphatidylcholine; IgG, IgA and IgM)
1 10 cc plain red top tube

_____ OB/GYN FACS profile (analysis of maternal antipaternal antibody)
Paternal: 2 10 cc ACD (yellow top) tubes
Maternal: 2 10 cc ACD (yellow top) tubes
Maternal: 1 10 cc red top tube



St. Francis

Hospital & Health Centers

Sisters of St. Francis Health Services, Inc.

Attn: Drawing Laboratory

Please call (317) 782-7187 in advance to schedule the test so we will know when to expect the package.

All tubes must be labeled with the following information:

- **Name of person being drawn**
- **Social security number (date of birth if available)**
- **Date and time of draw**

MAILING INSTRUCTIONS

- The blood must be drawn on **Monday, Tuesday, Wednesday or Thursday** and the blood must be shipped the day it is drawn.
- Do not centrifuge or separate the blood. Do not refrigerate. Room temperature is optimal.
- **THE COMPLETED TEST REQUISITION/BILLING FORM AND A COPY OF THE PATIENT'S INSURANCE, MEDICAID, OR MEDICARE CARD MUST BE INCLUDED IN THE BOX WITH THE BLOOD.**
- The blood must be shipped by Federal Express or DHL for next morning delivery. The shipping address is:

Dr. John A. McIntyre
HLA-Vascular Biology Laboratory
1500 Albany Street, Medical Arts Bldg., Suite 1109
Beech Grove, IN 46107

QUESTIONS ????? PLEASE CALL THE HLA-VASCULAR BIOLOGY LAB AT (317) 782-7187