Chimerism Testing Requisition

Ordering Physician:

Name: _____

Billing #: _____

Location: _____

Address: _____

Phone: _____

Fax: _____

Physician Signature: _____

Additional Copies To:

Name: _____

Address: _____

Phone: _____

Fax: _____

St. Joseph's Healthcare Hamilton
Histocompatibility Laboratory
St. Luke Wing, Level 4, Room L409
Hamilton Regional Laboratory Medicine Program
50 Charlton Avenue East, Hamilton, ON L8N 4A6
Phone 905-522-1155, ext. 34069

Patient Information:

Name: _____
Surname, First Name, Middle Name

Address: _____

Phone number: _____

Date of Birth (dd/mm/yy): _____

Gender: ☐ Male ☐ Female

Health Card Number _____ Version _____

Specimen ID: _____

**** Mandatory Information. Specimen cannot be processed without this data.**

Note: Specimen collection is NOT completed at this lab. Please proceed to any community lab for blood draw.

Specimen Submitted:

Date of sample: _____
(dd/mm/yy)

Time: (hh:mm) _____

Location/Ward: _____

_____

☐ Urgent ☐ Routine

☐ Peripheral Blood (8 mL if pre-transplant, 16 ml if post-transplant)

* All samples must be received in the laboratory within 48 hours of collection.

Ship at room temperature to address below. Do not freeze or spin.

Samples shipped on Fridays must be received in the lab by noon or a repeat will be required.

Diagnostic Testing:

CHIMERISM: ☐ **PRE-TRANSPLANT** - 8 mL EDTA

☐ Donor. Donor for: _____

☐ Recipient.

Transplant Date: (dd/mm/yy) _____

☐ **POST-TRANSPLANT** - 16 mL EDTA

Transplant Date: (dd/mm/yy) _____

Shipping Address:
Samples should be sent to

St. Joseph's Healthcare Hamilton
Histocompatibility Laboratory
St. Luke Wing, Level 4, Room L409
Hamilton Regional Laboratory Medicine Program
50 Charlton Avenue East, Hamilton, ON L8N 4A6

Contact Us:

St. Joseph's Healthcare Hamilton
SJH HLA 905-522-1155 x34069
Weekdays, Mon-Friday
8 am to 4 pm

708127 (2026-03)

Lab Requisition *(EPIC document type)*