HAMILTON REGIONAL LABORATORY MEDICINE PROGRAM

HLA DNA TYPING REQUISITION Revision Date: January 21, 2026

Referring Client/Lab: _____

Referring Client/Lab Address: _____

Patient's Name:_____ Patient's Date of Birth: _____ (DD/MM/YYYY)

Accession number: _____

1. Is test ordered for organ transplant? Y if Yes, proceed to next question
   N if No, proceed to question 5

2. What type of organ transplant?

   ❑ Bone Marrow ☐ Lung ☐ Heart
   ❑ Renal ☐ Liver ☐ Pancreas
   ❑ Other (Specify): _____

3. Is patient a potential donor or a potential recipient? _____

   If recipient, direct patient to a transplant program in your region of Ontario.If neither, proceed to question 5.

4. Is the potential recipient a resident of Ontario?

   Y If Yes – Not Approved testing should be performed by recipient centre

   N If No – Approved - Low Resolution HLA A,B, DRB1 will be performed (**Test Mnemonic:** HLATT)

5. If this request is for non-transplant HLA testing, please select from the following list of pre-approved tests:

Disease Association	HLA Type Association	HLA Test	Test Mnemonic
❑ Allopurinol Sensitivity	B*58:01 Allele	B locus	HLAB58
❑ Behcet's Uveitis	B*51 Allele	B Locus	HLAB51
❑ Birdshot Uveitis	A*29 Allele	A Locus	HLAA29
❑ Celiac Disease	DQA1*05 DQB1*02, DQB1*03:01 (7) or DQB1*03:02(8)	Low Resolution DQB1	HLADQ2.DQ8
❑ Narcolepsy	DQB1*06:02 Allele	High Resolution DQB1	HLADQB1
❑ Carbamazepine Sensitivity	B*15:02 Allele	High Resolution B*15	HLAB15
❑ Tebentafusp Sensitivity	A*02:01 Allele	High Resolution A*02	HLAA2
❑ Spondylo-arthropathies	B*27	Low Resolution B*27	HLAB27PCR
❑ OTHER. Please Specify: _____ **Any requests for HLA Testing other than the ones listed above or if the result is required in less than 15 days, the physician <u>must</u> contact the Histocompatibility Lab for Director approval (905)522-1155 ext 34069**			HLAOTHER

Physician's Name:_____Physician's Signature: _____
(Please print)

Physician's Address_____ Telephone # :_____