Texas Medical Specialty, Inc.

Texas Medical Specialty, Inc.
HLA & Molecular Laboratory
7777 Forest Lane, Suite C-740
Dallas, TX 75230
Tel: 972-566-6278

TEST REQUISITION FORM

Patient Information

Name: _____
Date of Birth: _____
ID or SS#: _____
Race (Circle One): Cauc Hisp NatAm Blk Asian Other

Date Received: _____
Lab #: _____

Requesting Information

Requesting Physician: _____
Date / Time Collected: _____
Drawn By (Initials Only): _____
Type of specimen: _____

Test Requested:

- O **Cancer Genes (15-gene Basic Panel)**
- O **Cancer Genes (50-gene Hot Spot Panel)**
- O **EGFR**
- O **Epi proColon screen**
- O **Bacteria/Mycobacteria (16S, NGS)**
- O **KIR Typing**
- O **Other:**_____
- O **HLA-A,B,C, Low Resolution**
- O **HLA-A,B,C, High Resolution**
- O **HLA-DR, DQ, DP, High Resolution**
- O **STR Engraftment Donors ID**_____
- O **STR Engraftment, Fractionated**

Donor ID_____

INSTRUCTIONS:

1. One-10ml yellow-top (ACD anticoagulant) or purple-top (EDTA anti-coagulant) tube. Keep the tubes at room temperature or on ice. **No specimen should be kept on dry ice.**
2. OR mouth swabs (4 Q Tips)
3. Tissue, Fresh, frozen or paraffin embedded
4. Other Body fluids – Call for approvals
5. Deliver to Building C-740 or call X-6278 for pick-up
6. Send this Requisition form with specimen or fax to 972-566-2357

Requesting Center: _____

Contact Person: _____

Phone #: _____ **Fax #:** _____

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