Clear Fields

LIFESouth CommunityBloodCenters

Request for Immunohematology Services

Sample Requirements: 10 to 15 mL of blood collected in three EDTA purple-top tubes.

If a crossmatch is requested: (1) additional 3-mL EDTA sample tube (collected at a different draw time) is required, *if patient blood type unknown*

Referral Information

Contact Name:	Phone:	Fax:
Hospital/Facility:	City/State:	
Date/Time Requested:	Date/Time Needed:	

Urgency: ☐**STAT** ☐**ROUTINE/ASAP**

Patient Information/History (or apply addressograph)

Patient Name: _____ (Last) _____ (First) _____ (Middle Initial)

Sex: ☐M ☐F	Physician:
DOB:	Diagnosis:
Patient ID or MR#:	Medications (attach additional documentation if necessary):
Race:	☐Daratumumab ☐Other:

Lab Values

ABO/Rh (if known):	Current Hgb/Hct:	Current platelet count:
Phlebotomist(s) Printed Name or ID:		
Phlebotomist(s) Signature:		
Collection Date(s)/Time(s):		

Transfusion History

Has patient ever been transfused? ☐No ☐Yes; within last 3 months? ☐No ☐Yes

Products previously transfused (check all that apply): ☐RBC; date: ☐Platelets; date: ☐Plasma; date:

Known RBC/platelet antibodies? ☐No ☐Yes; specify:

Pregnancy History ☐N/A

Number of previous pregnancies:	Currently pregnant? ☐No ☐Yes	Received Rhlg? ☐No ☐Yes; date:

Reason for Submission *(attach copy of hospital blood bank workup)*

☐ ABO/Rh Typing Discrepancy	☐ Neonatal Evaluation/HDN	☐ Elution ☐ Other:
☐ Antibody Identification	☐ Incompatible Crossmatch	☐ Platelet Refractory
☐ Positive Direct Antiglobulin Test (DAT)	☐ Suspected Transfusion Reaction	☐ Red Cell Genotyping-Patient Common Panel

Component Information

Blood Component **Quantity Needed**

☐ Red Blood Cells; _____
AC Type (optional): ☐*Any* ☐*AS-1* ☐*CPDA-1* ☐*Other:* _____
☐ Platelets _____
☐ Other; _____
specify: _____
☐ Only accept ABO/Rh identical

Special Request(s)

☐ Platelet Crossmatch ☐ Leukoreduced (CMV safe)
☐ Sickle Cell Negative ☐ Irradiated
☐ Pediatric Units/Aliquots ☐ HLA Matched
☐ Washed
☐ Other: _____

Crossmatch Requested? ☐No ☐Yes; *if yes, it is recommended that samples for platelet crossmatch be tested 24 hours after collection or less.*

☐ Check here to request to extend the sample's age for platelet crossmatch for up to 48 hrs from collection.

Has the patient been previously typed for ABO/Rh (using a sample separate from the one being submitted?) ☐Yes ☐No

- If yes: ABO/Rh Result: _____ Date performed: _____ Tech: _____
- If no: An additional 3-mL EDTA sample (drawn at a separate collection time) must be submitted.

For IRL Laboratory Use Only

Testing performed by: ☐GA-IRL ☐FL-IRL Comments: Time sample received in IRL: Previous record check performed by: Date:	Shipping Ticket #:
Reviewed by:	Date: