



# 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 (Complete section or apply addressograph. Include all available information.)

Patient Name: _____		
Last	First	Middle Initial
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Physician:	
DOB:	Diagnosis:	
Patient ID or MR#:	Medications (attach additional documentation if necessary):	
Race:	<input type="checkbox"/> Daratumumab <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes; within last 3 months? <input type="checkbox"/> No <input type="checkbox"/> Yes
Products previously transfused (check all that apply): <input type="checkbox"/> RBC; date: _____ <input type="checkbox"/> Platelets; date: _____ <input type="checkbox"/> Plasma; date: _____
Known RBC/platelet antibodies? <input type="checkbox"/> No <input type="checkbox"/> Yes; specify: _____

### Pregnancy History N/A

Number of previous pregnancies: _____	Currently pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes	Received Rhlg? <input type="checkbox"/> No <input type="checkbox"/> Yes; date: _____
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## Reason for Submission (attach copy of hospital blood bank workup)

<input type="checkbox"/> ABO/Rh Typing Discrepancy	<input type="checkbox"/> Neonatal Evaluation/HDN	<input type="checkbox"/> HLA Class I Typing	<input type="checkbox"/> HLA Antibody Screen
<input type="checkbox"/> Antibody Identification	<input type="checkbox"/> Incompatible Crossmatch	<input type="checkbox"/> Platelet Refractory	<input type="checkbox"/> HLA Antibody ID (if positive screen)
<input type="checkbox"/> Positive Direct Antiglobulin Test (DAT)	<input type="checkbox"/> Suspected Transfusion Reaction	<input type="checkbox"/> Red Cell Genotyping-Patient Common Panel	<input type="checkbox"/> Elution <input type="checkbox"/> Other:

## Component Information

Add on request? Yes (same sample from previous day) No

<b>Blood Component</b>	<b>Quantity Needed</b>	<b>Special Request(s)</b>
<input type="checkbox"/> Red Blood Cells; AC Type (optional): <input type="checkbox"/> Any <input type="checkbox"/> AS-1 <input type="checkbox"/> CPDA-1 <input type="checkbox"/> Other: _____		<input type="checkbox"/> Platelet Crossmatch <input type="checkbox"/> Leukoreduced (CMV safe)
<input type="checkbox"/> Platelets		<input type="checkbox"/> Sickle Cell Negative <input type="checkbox"/> Irradiated
<input type="checkbox"/> Other; _____ specify: _____		<input type="checkbox"/> Pediatric Units/Aliquots <input type="checkbox"/> HLA Matched
<input type="checkbox"/> Only accept ABO/Rh identical		<input type="checkbox"/> Washed
		<input type="checkbox"/> 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.

<b>For IRL Laboratory Use Only</b>	<b>Assession Number</b>
Testing performed by: <input type="checkbox"/> GA-IRL <input type="checkbox"/> FL-IRL	SAU: <input type="checkbox"/> Hx <input type="checkbox"/> Conf <input type="checkbox"/> Fresh <input type="checkbox"/> Vol indicated
Comments:	<input type="checkbox"/> Leukoreduced <input type="checkbox"/> Irradiated <input type="checkbox"/> CMV - <input type="checkbox"/> # Units filled
Time sample received in IRL:	<input type="checkbox"/> HbS -