



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 <input type="checkbox"/> 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:

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 Rx	<input type="checkbox"/> Red Cell Genotyping-Patient Common Panel; WBC Count: _____	<input type="checkbox"/> Elution <input type="checkbox"/> Other:

Component Information

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

Blood Component	Quantity Needed	Special Request(s)
<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? <input type="checkbox"/> No <input type="checkbox"/> Yes; if yes, it is recommended that samples for platelet crossmatch be tested 24 hours after collection or less. <input type="checkbox"/> 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?) <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> GA-IRL <input type="checkbox"/> FL-IRL	<input type="checkbox"/> SAU Hx <input type="checkbox"/> SAU Conf <input type="checkbox"/> Fresh <input type="checkbox"/> Vol indicated <input type="checkbox"/> HbS-
Comments:	<input type="checkbox"/> Leukoreduced <input type="checkbox"/> Irradiated <input type="checkbox"/> CMV- <input type="checkbox"/> # Units filled
Accession Number:	Pending # Units: _____ Reviewed/Verified by: _____
	Time sample received in IRL: _____