**\***Patient’s Name/ID Birth Date

\*Date Collected \*Date Submitted \*Sex

\*Hospital/Facility

\*Physician Requesting Test(s)

Information on test methods, performance specifications and interpretation are available on request.

\*CLIA Required Information, CFR 493.1241

**Clinical History:** Diagnosis Race

Prior transfusions: 🞏Yes 🞏 No

Date of most recent red cell transfusion Number of Transfusions

Pregnancy: Is patient now pregnant? Gravida Para

Drug History: List or attach all medications patient is or has recently received:

**Test Requested**: 🞏 ABO grouping 🞏 Investigate Positive Direct Antiglobulin Test

🞏 Rh typing 🞏 Investigate Possible Transfusion Reaction

🞏 Antibody Identification 🞏 Investigate Possible Hemolytic Disease of Newborn

🞏 Other (specify)

Patient ABO Rh Direct Antiglobulin Test: Poly IgG C’

Antibodies Identified:

Antibody Reactivity: 🞏Tube Test: 🞏22C 🞏37C 🞏IAT 🞏Saline 🞏LISS 🞏PEG 🞏Enzymes

🞏Gel 🞏Solid Phase Other

Comments:

**Provide Units for Transfusion**:

ABO/Rh: Number of units Antigen negative for:

Special Requirements: 🞏 CMV-negative 🞏Irradiated Other:

Date and time needed: Urgency: 🞏 Routine 🞏 STAT

Please write or attach additional information on back of this form.

* Most investigations require a minimum of 14-20 mL anticoagulated blood.
* Do not submit specimens collected in gel-type separation tubes.
* Specimens must be packaged to prevent leakage and may be shipped at room temperature or refrigerated.

Date: Personnel authorized to request tests/receive results:

|  |
| --- |
| **For CBC Use Only** |
| Billing Entered into El Dorado By: Date: |
| Results Reviewed by: Date: |
| Results Telephoned to Hospital To: Date: By: |

FAX: Telephone:

**Send to:**

**Community Blood Center**

**Immunohematology Reference Lab**

**4040 Main, Kansas City, MO 64111**

From:

**Ship**: 🞏 STAT 🞏 ASAP 🞏 Routine

**Test:** 🞏STAT 🞏 ASAP 🞏 Routine

Please call IRL at 816-968-4053 prior to sending sample.