Immunohematology Laboratory Testing Request

431 East Locust Street Des Moines, IA 50309/5436 F Street, Omaha, NE 68117

THIS FORM SHOULD ONLY BE USED IF BLOODHUB IS UNAVAILABLE

- **Facility Name:** _____
- **Priority**: STAT ☐ (within 8 hours of receipt) ASAP ☐ (within 24 hours of receipt) Routine ☐
- Call (515)309-4880 or (888)244-2928(Des Moines) or (515)309-4959 (Omaha) before sending specimen
- **Carefully label all tubes** and fill in this **form COMPLETELY**
- **All tubes must be labeled with patient's full name, identification number, date & time drawn and phlebotomist's ID. Inadequately or illegibility labeled samples will be rejected. Data on tubes must match data recorded on consultation request form.**
- **Send 20 ml EDTA anticoagulated blood and on 10 ml red top tube.** Please send pre-transfusion RBC sample, if available

PICKUP INFORMATION

Does a courier need to be called for pickup? ☐ Yes ☐ No

Is this coming with your route driver? ☐ Yes ☐ No

PATIENT AND SAMPLE INFORMATION

Patient Name: Last _____ First _____ Middle _____

Date of Birth: ____/ ____/ _____ Gender_____ Race_____

Patient ID# _____ Patient Requirements ☐ Irradiated ☐ HgbS Neg ☐ CMV Neg

Patient Status ☐ Inpatient ☐ Outpatient Patient Diagnosis_____ Patient Hgb_____

Sample ID_____ Date Collected:____/____/_____ Time Collected_____ Phleb ID_____

Volume of sample being sent_____

Date Submitted: ____/ ____/ ____ Race: _____

Diagnosis: _____ Previously Submitted to LS? Y N

Ordering Physician: _____ Do you have a physician order to transfuse? Y N

ORDER INFORMATION

Ordering Physician_____ Physician order to transfuse? ☐ Yes ☐ No

Date and time of transfusion_____ Number of units to crossmatch_____

Tests Requested

☐ ABORh ☐ Antibody ID ☐ Antibody Titer ☐ Antigen Typing (Antigens_____)

☐ Crossmatch ☐ DAT Investigation ☐ Elution ☐ Molecular DNA Profile

☐ Neonatal ABORh ☐ Neonatal DAT ☐ Transfusion Reaction Workup

HOSPITAL TEST RESULTS

ABO/Rh _____ Known Antibodies:_____

Facility where previous antibodies were identified_____

DAT ☐ Positive ☐ Negative ☐ Not Performed

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Antibody Screen Results:

Cell I ☐ Not Performed ☐ Negative ☐ w+ ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+ ☐ Mixed Field

Cell II ☐ Not Performed ☐ Negative ☐ w+ ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+ ☐ Mixed Field

Cell III ☐ Not Performed ☐ Negative ☐ w+ ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+ ☐ Mixed Field

What methodology did you use? ☐ LISS tube ☐ PeG tube ☐ MTS Gel Card ☐ Solid Phase

Copy of test results coming with sample? ☐ Yes ☐ No ☐ N/A – no testing performed at hospital

TRANSFUSION HISTORY

Transfused within last 3 months? ☐ Yes ☐ No ☐ Unable to determine

Number of units and date(s) _____

Transfused prior to last 3 months? ☐ Yes ☐ No ☐ Unable to determine

Number of units and date(s)_____

Any transfusion reactions? ☐ Yes ☐ No Type of reaction _____

For female patients – currently pregnant or in the past 3 months? ☐ Yes ☐ No ☐ NA

Date of RhIG injection ___/____/_____ Previous pregnancy? ☐ Yes ☐ No ☐ NA

Transplant patient? ☐ Yes ☐ No Date of Transplant _____/____/_____