

IMMUNOHEMATOLOGY LABORATORY REQUEST FORM

*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: _____
FAX: _____ Telephone: _____

For CBC Use Only		
Results Review by:	Date:	
Results Telephoned to Hospital To:	Date:	By:

SEND TO:

**COMMUNITY BLOOD CENTER
IMMUNOHEMATOLOGY REFERENCE LAB
4040 MAIN, KANSAS CITY, MO 64111**

From: _____

Ship: STAT ASAP Routine

Test: STAT ASAP Routine