Community Blood Center of Greater Kansas City 4040 Main St., Kansas City, MO 64111
KC-FORM-0616 Immunohematology Laboratory Request Form Rev: 07
Phone: 816-968-4053 **Fax: 816-277-0757**

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
☐ Rh typing
☐ Antibody Identification
☐ Super DAT
☐ Investigate Positive Direct Antiglobulin Test
☐ Investigate Possible Transfusion Reaction
☐ Investigate Possible Hemolytic Disease of Newborn
☐ Antibody Titration
☐ 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.
- See page 2 for collection and volume requirements
- 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		
Billing Entered into El Dorado By:	Date:	
Results Reviewed 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

Test Requested	Preferred Volume (Total)	Minimum EDTA Plasma Volume*	Notes**
ABO Grouping	14-20 mL	6 mL	
Rh Typing	14-20 mL	6 mL	
Antibody Identification	14-20 mL	6 mL	
Antibody Titration	14-20 mL	10 mL	
Cold Antibody Titration Donath-Landsteiner Thermal Amplitude Test	10 mL clotted + 7 mL EDTA	NA	Specimen tube maintained at 37°C until physically separated
Isohemaglutinin Antibody Titration	14-20 mL	10 mL	
Investigate Positive DAT	14-20 mL	6 mL	
Transfusion Reaction	14–20 mL + donor segments	6 mL	
Phenotype	7-14 mL	NA	
Super DAT	7-14 mL	NA	
HDFN	**Newborn**: 7-10mL cord blood OR 2-3mL whole blood **Maternal**: 14-20 mL **Paternal**: 14-20mL	**Maternal and Paternal**: 6mL **Newborn**: 1mL	Cord blood is acceptable for newborns
Molecular	5 mL EDTA whole blood	NA	

***** *Minimum refers to total plasma required from EDTA specimen.*

***** *For children, sample requirements may be adjusted on a case-by-case basis after communication with laboratory management.*