Central California Blood Center | TOGETHER, LIFE FLOWS FROM HERE.

CCBC IRL Referral Form

Dr. Patrick C. Sadler, Medical Director

Referral form completed by: _____

Date/Time: _____

Patient Name: _____ DOB: _____ Ethnicity: _____ Sex: _____

Requesting Physician: _____ Hospital: _____ Hospital ID: _____Diagnosis/Medication: _____

Has the patient been transfused in the last 3 months? No ☐ Yes ☐ if yes, date and # of units: _____

Has the patient been pregnant in the last 3 months? No ☐ Yes ☐ If the patient received RhoGAM, date: _____

☐Routine ☐STAT* Hgb/HCT _____ Active Bleed? No ☐ Yes ☐ Specimen Collection Date: _____

Do you have a request from a physician to transfuse this patient? No ☐ Yes ☐ Date to Transfuse: _____

Hospital Test Results:

ABO/Rh: _____ Current Antibody Screen: _____ Previously Identified Antibodies _____

DAT: Poly _____ IgG _____ C3 _____ Auto Control _____

Describe current transfusion problem and/or Reason for Submitting: _____

Requested Testing to be done at CCBC:

☐Complete Antibody ID Workup (21 mL EDTA Whole Blood) ☐ABO Discrepancy

☐ Level 1 Phenotype (Rh and K) ☐ Level 2 Phenotype (extended Rh, K, Fy, Jk, Ss, MN)

Note: Please enclose request form with blood specimens and copies of all antigrams and results.

*Patient RBC and HLA Genotyping Request:

☐HLA Class I low resolution DNA Type including Antibody Report (HLA-A, B, C)
(30 mL ACD-A (yellow top) & 10 mL Clot (red top) → keep at room temperature)

☐RBC Complete Genotype (5 mL EDTA (purple top))

☐RBC Rh Genotype (5 mL EDTA (purple top))

☐RBC Weak D Genotype (5 mL EDTA (purple top))

*Special Product Request:

Number of units requested: _____ **Date and Time needed:** _____

☐ HLA Matched Platelets (HLA testing already done) ☐ Deglycerolized RBCs ☐ Washed RBCs

☐ Sickle Cell Testing ☐ Irradiated ☐ CMV Negative

☐ HCT Testing ☐ HCT Range _____

☐ Antigen Negative RBCs ☐ Historical or ☐ Screened

Units negative for:

☐ D ☐ C ☐ E ☐ c ☐ e ☐ K ☐ Fy^a ☐ Fy^b ☐ Jk^a ☐ Jk^b ☐ S ☐ s ☐ M ☐ N

Additional: _____

*Will incur additional fees

Blood Specimen Label Should Contain:

1. Patient Name
2. Patient identifying number (Medical Record #)
3. Date specimen drawn
4. Phlebotomist initials

Note: Incorrectly labeled specimens will not be tested

Request received by CCBC Date/Time: _____

Notified Hospital of request receipt: _____

Order completed Date/Time: _____

Immunohematology Reference Lab

office: (559) 389-5483 | fax: (559) 225-7490 | mobile: (559) 754-6943

Email: IRL@donateblood.org Website: donateblood.org

IRL HOURS OF OPERATION: Monday through Friday 7 AM – 5 PM

After hours or weekends please contact Hospital Services at (559) 224-8244 | fax: (559) 224-6023